SPEECH AND LANGUAGE THERAPY:

GENDER, SCIENCE AND

THE HEALTH DIVISION OF LABOUR

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Abstract

This research arose from concerns over the marginal position of speech and language therapists within the UK health care system, at a time when a case based on equal pay legislation comparing their work with that of clinical psychologists nears completion. While quantitative data confirm a difficulty for the NHS in recruiting and retaining speech and language therapists, no qualitative research has explored their work experiences within a sociological framework. The present study aims to address this gap. The empirical findings are based on qualitative interviews with forty speech and language therapists which employed feminist principles in research methodology including open-endedness, disclosure of values and reciprocity.

Themes emerging included the 'invisibility' of the profession in accessing careers advice and gender-stereotyping of subject choices and careers advice at school. In contrast to the humanistic elements which led people into speech and language therapy, the professional education emphasised the scientific aspects of human communication, reflecting a medicalised view of health. Lesser attention was paid to humanistic subjects such as counselling and to the therapeutic applications of formal teaching. Therapists' clinical experiences focused on the relationship between work in the public and private spheres, organisational concerns and the nature of clinical practice. For instance, treatment for people with communication impairments was regarded as a low priority owing to the tendency of formalised health care to prioritise bodily health over mental and communicative well-being.

The research considers whether the 'scientisation' of the profession is an effective route to counteract its marginalisation, since in pursuing this route it is required to distance itself from the female-gendered elements of its practice. This dilemma is examined against wider social concerns in which the work of women in the 'reproduction' of people is devalued on a global scale while the 'mainstream' activity of scientific work continues to be highly-prized.

To my mother, Sylvia Tucker, for her steadfast support;
and in memory of Jacqueline Cheney and Ann Varah

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Chapter 1

Introduction

1.1 Preamble

This thesis explores an area which long concerned me as a practising speech and language therapist, namely the undervaluing and marginalisation of speech and language therapy within the health care system.

Despite the length of professional education and the complexity of problems with which speech and language therapists deal, I was frequently puzzled as to why the work was perceived from the outside as a job requiring relatively little training and few (if any) qualifications. For instance, a colleague of mine was once asked, 'Do you need any qualifications to be a speech and language therapist?'. I myself often encountered patronising attitudes from other staff, particularly those higher up in the 'pecking order'. I well remember being confronted by a young medical house officer with the question 'How are your little challenges coming on today?' This was in spite of the fact that we worked on a stroke team where close multidisciplinary co-operation was the norm.

My initial attempts to try and account in some way for the low status of speech and language therapy drew on psychological explanations of career choice (Bebbington 1993). Finding these largely inadequate I looked to sociological frameworks as a basis for 'unpacking' the issues in question. I argue in this thesis that the undervaluing of speech and language therapy cannot be explored without considering the gendered division of labour in healing work. I further assert that science has a major role in the defence and contestation of gender divisions in the 'caring' professions and I draw attention to the ways in which 'scientisation' is used as a professionalisation strategy in speech and language therapy. In the thesis I employ the term 'scientisation' to refer to the ways in which the knowledge domains of the

profession take on a scientific character. These include the idea of human communication as a physical process involving sound waves, anatomical movement, syntactic forms and so on. I further show how these divisions echo the gender divide in other spheres of work.

The purpose of this introduction is to describe how I came to adopt my current perspective. I begin with a short description of the work of speech and language therapists. This is followed by a brief history of the profession. I then consider how this study addresses a 'gap' in the sociology of work. In the next section I describe in more depth how my interest grew in this area. I then discuss my rationale for adopting a feminist perspective and finally I outline the contents of the thesis.

1.2 Speech and language therapy: its role and history

Speech and language therapists identify, assess and treat communication and swallowing disorders in children and adults. They work closely with a variety of other health and education staff including teachers, health visitors, physiotherapists, occupational therapists, dietitians, doctors, nurses and psychologists. Most are employed by the National Health Service, though increasing numbers are working in private practice or education. They are based in community clinics, hospitals, schools, language units and day centres, and some provide domiciliary services. The profession is regulated by the Royal College of Speech and Language Therapists (RCSLT). There are currently 6,000 practising therapists. Qualification is via a three or four-year degree course or a two-year postgraduate MSc.

Speech and language therapy is widely regarded to have emerged as a recognised occupation in the early part of the century[1]. In 1906 the first local authority provision for people with stammers was established in Manchester. This was followed by the opening of three hospital speech clinics in London. Provision increased after the First World War when therapists were called upon by the medical profession to treat shell-shocked and head-injured soldiers. There then followed the establishment of several

[1]For accounts of the history of the profession, see Quirk (1972) and Robertson et al (1995).

training schools and professional associations. Much of the early work of the 'speech correctionists' or 'vocal therapists' was based on the emerging theoretical sciences of the physics of sound, linguistics, phonetics, neurology and educational theory. Currently the profession continues to identify with its scientific roots, though the scope of its work has broadened to the extent that it is barely recognisable from its origins.

This study, based on interviews with practising therapists, sets out to examine the position of the profession within the context of health care delivery as a whole. It also aims to look at the wider net of social forces which influence the position of women in the labour market. This approach represents a departure from previous research into the careers of speech and language therapists which has tended to focus on the profession itself. Nevertheless, this literature provides important background material such as providing historical detail and quantitative information on trends in recruitment and retention.

Ninety-eight per cent of speech and language therapists are estimated to be women, though men form a small but growing minority of speech and language therapy students, a pattern noted in other female professions including physiotherapy and nursing (Bebbington 1995). It will be seen in Chapter 4 that as in other occupations, men in speech and language therapy are more visible in the higher ranks of management, research and teaching. Much has been written about women entering the male-dominated professions - a process which has sometimes been referred to as the 'feminisation' of work, including medicine (Elston 1980, Lorber 1984, Witz 1992, Brooke 1993, Notzer and Brown 1995), science (King 1994, Rose 1994), surveying (Greed 1991, 1994), planning (Greed 1994) and law (Evetts 1984, Dyer 1997). The significance of gender for the female occupations is also a burgeoning area of interest, including studies which have looked at secretarial work (Pringle 1989), midwifery (Versluysen 1981, Witz 1992, Allison and Pascall 1994), nursing (Gamarnikow 1978, Salvage 1985, Mackay 1989, Witz 1994, Walby and Greenwell 1994, Davies 1995) and radiography (Cockburn 1985, Witz 1992). This material is

useful for comparisons and contrasts with speech and language therapy. I would agree with Greed (1991) that it is important to consider the position of women in other professions, even in areas which appear to have tenuous connections with speech and language therapy, for as will be seen later, stereotypes about 'women's work' abound in even the most 'male' of professions.

1.3 The personal and the political

I have been a speech and language therapist and member of the RCSLT since 1982 during which time I have worked as a clinician, manager and researcher. My interest has been in the field of adult work, particularly in the care of elderly people with communication problems associated with cerebrovascular disease, Parkinson's disease and dementia. Latterly, however, I have been more involved in research than clinical practice. This places me in the peculiar position of 'insider-outsider' which other researchers have described[2], for the vast majority of people in the profession are hands-on practitioners. The ambiguity of my position is perhaps felt even more acutely given that my research interests concern the careers of speech and language therapists themselves rather than the therapy itself, the latter being the usual subject of academic study.

My interest in this area arose from concerns as to why, given the fundamental importance of communication to the human being, speech and language therapy does not appear to receive the recognition it deserves. As Spender (1980) has pointed out:

> Language helps form the limits of our reality. It is our means of ordering, classifying and manipulating the world. It is through language that we become members of a human community, that the world becomes comprehensible and meaningful, that we bring into existence the world in which we live (p.3).

In my eleven years as a full-time, practising therapist in the NHS, it seemed that battles needed to be fought on all fronts. In my numerous discussions with other therapists we would constantly bemoan our working conditions, including the heavy caseloads and lack of staff to cover them, difficulty gaining adequate space in which to work, the shortage of essential equipment and the many sites people were often

required to cover during the working week. This is not to say that all these conditions existed for every therapist. Indeed, jobs in specialist units such as stroke wards or language units often provided better than average facilities, especially when new monies had been made available and funds apportioned for speech and language therapy. It was also my feeling, and I believe that of other therapists, that our area was generally seen as a low priority within the health care system, an extra item to be tacked on almost as a 'luxury' in times of cut-backs and rationalisations in an ailing health service. To some extent this seemed justifiable with constant talk, most notably in the last decade, of the need for 'cost-containment' in public spending.

The poignancy of this situation came over to me in the late eighties when I was working in the Welsh valleys in a former mining community. The provision at that time of rehabilitation for people who had had strokes was limited, in that following hospitalisation therapy services were sparse and in some areas non-existent. I recall attending a talk on visual agnosia[3] after stroke and my immense frustration at thinking there were insufficient therapists to even diagnose such a problem, let alone do something about it.

Concerns about the profession were further compounded by events which occurred in the mid-eighties on the subject of pay. There was considerable dissatisfaction at the time that speech and language therapists' salary levels were falling behind those of other therapy professions. This followed a move by the union representing speech and language therapists, ASTMS, to pull the profession out of the Whitley Council negotiating body which determined pay for non-medical staff. There was much activism in South Wales and Britain generally, which attempted to draw the government's attention to the pay issue. This culminated in 1987 with the union mounting a test case against the Department of Health using legislation contained in the Equal Pay Act 1970 which sought to 'prove' that the work of speech and

[2]See for example, Ladner 1987, Greed 1991, Marshall 1994.
[3]A disorder resulting from neurological damage characterised by normal vision, but an inability to recognise seen objects.

language therapists was of equal value to that of clinical psychologists and hospital pharmacists.

In the late eighties and early nineties a number of reports and articles appeared concerning recruitment and retention problems in the profession (Ware 1988, Rooney 1989, Manpower Advisory Group 1991). The Manpower Advisory Group carried out a survey of all Health Regions in the UK. This indicated a decline in the numbers of therapists in practice after the age of thirty, and assumed this could be explained by the fact that therapists left to have children:

> In a predominantly female profession, the fact that such a large proportion of speech therapists are so young makes the service vulnerable to severe maternity leave disruption. The drop in numbers of speech therapists after the age of 30 suggests that speech therapists who leave the profession to have children are not returning to work in the same field (p.1).

The work of Ware (1988), a speech and language therapy manager, told a different story. Her research arose out of concerns that within South-East Thames Regional Health Authority there was a significant drop in the numbers of therapists after the age of thirty. Her report *Why do they leave?,* based on research in the South-East Thames Region, found that job satisfaction and pay were important factors in therapists' career decisions and that difficulty with retention could not be explained purely on account of family reasons. Studies have pointed to similar patterns of recruitment and retention in the other female-dominated health occupations including research into the Professions Allied to Medicine as a whole (Buchan and Pike 1989), occupational therapy (Borikar and Goodban 1989), nursing (Williams et al 1991, Francis et al (1992) and midwifery (Robinson 1986). There was thus a lingering sense in my mind that the issues facing speech and language therapy were part of a wider problem.

In an attempt to find possible answers to these concerns I embarked on an MSc, choosing as my research topic the subject of speech and language therapy students' career intentions (Bebbington 1993). I hypothesised that people left the profession because they had made a career choice inappropriate to their interests. This approach essentially located the problem within the personalities involved and did not consider

broader mechanisms which lead to the devaluation of certain forms of work. The research found that older students and postgraduates taking the two-year accelerated course were 'significantly more likely' (that is on quantitative measures) to want to practise on completing the course. Younger students and undergraduates were less sure they would pursue careers in speech and language therapy once qualified. This finding was unsatisfactory in that it could still not account for the wastage of therapists from the NHS. Furthermore, a model which assumed the problem was down to the characteristics of individuals failed to take into account external factors such as pay and conditions in the NHS.

1.4 Adopting a feminist perspective

On completing the research I felt I was no nearer to understanding the problem. I then came across Ann Oakley's essay *On the Importance of Being a Nurse* (Oakley 1993) in which she argues that nursing cannot be understood without reference to two forms of the division of labour - the division of labour in health care and the division of labour between the sexes. Though more women are entering medicine, it remains a male-dominated profession. Nursing, on the other hand, continues to be female-dominated. Doctors' training and practice reinforce cultural ideals of masculinity, encouraging behaviour which is rational, scientific and detached but while medicine has accrued status and recognition through its ability to 'cure' illness, the health care work provided by women, whether paid or unpaid, goes largely unacknowledged. Oakley points out that the vast majority of health care work in the world is performed by women. Since women's labour as health care workers is generally low status and low-paid, their confidence is likely to be undermined, as Oakley says in relation to nursing:

> The dilemmas of doing good and feeling bad apply to nurses, just as they do to women in general. Insofar as caring is the signal quality and main work of nurses, they are likely to come up against two barriers: first, they will not achieve a social and financial status which underlines the inner feeling that nursing is good work - instead the external rewards of nursing are likely to undermine nurses' confidence in the performance of caring work. Second, it will be difficult to feel, day in and day out, and in the face of so many counterchallenges, that communication with patients and acting as a midwife to patients' own articulation of their own needs is truly as valuable work as microsurgery diagnoses with body-scanners, and intricate immunological tests (p.48).

Oakley's work confirmed my hunch that the problems of speech and language therapy were not confined to the occupation and could be linked to the undervaluing of women's work in general.

My perspective thus changed and I sought to explore the contention that the marginalisation of speech and language therapy could be explained by the fact that most clinicians are women. Further reading drew my attention to the significance of 'science' in the professionalisation of occupations, in particular, medicine and also the significance of 'science' in defending and challenging occupational boundaries. As was pointed out in section 1.1, speech and language therapy continues to identify with its scientific orgins, perhaps not surprising given the importance of science and technology in contemporary times. I thus became interested in the interplay between gender and science and the role of these constructs in influencing the status of speech and language therapy.

I decided to conduct open-ended interviews in order to explore these issues. While the intention was not to exclude male speech and language therapists in the sampling, the research methodology was influenced by feminist concerns to address the silences in women's experiences. As Reinharz (1992) points out,

> Feminist researchers who have done interview studies have modified social science concepts and created important ways of seeing the world. By listening to women speak, understanding women's membership in particular social systems, and establishing the distribution of phenomena accessible only through sensitive interviewing, the feminist interview researchers have uncovered previously neglected or misunderstood worlds of experience (p.44).

This approach to research was a departure from my previous research training which was principally concerned with statistical methods to determine the 'significance' or otherwise of a relationship between one variable and another. This perspective assumes the objectivity of the researcher whose person remains 'hidden' in the research process. Feminism has called into question this view of intellectual enquiry, arguing that the consciousness of the researcher is crucial to the whole research enterprise, as Sherif (1987) notes in her critique of experimental psychology:

> .....the standard research situation is loaded with opportunity for bias. The opportunity starts when a researcher decides what to study and it continues to widen during decisions about how

> to study the subject. What is the individual being studied to do during the research? The researcher decides, of course, often in highly arbitrary ways dictated by custom in previous research, not by what the person does or is doing in daily life. What are to be included as the all-important independent variables? Which aspects of the individual's behavior are to be noticed and which ignored during the research experience? The researcher makes all these decisions, often forgetting at times that he or she is a human being who is part of the research situation too (p.47).

It has thus become common practice within feminist research for the researcher to declare her position. Indeed, Stanley and Wise (1983) suggest this is essential, given the basic tenet of feminism that 'the personal is political'. They insist that:

> ...the crucial importance of the personal must also include an insistence on the importance, and also the presence, of the personal *within research experiences* as much as within any other experiences. But, more than this, the personal is not only the political, it is also the crucial variable which is absolutely present in each and every attempt to 'do research'.....(p.157).

On occasion it has been said that I need to view the situation of speech and language therapists more 'objectively', but this has not been my aim and I identify closely with Greed (1991) who as a surveyor studying surveyors has said that in doing her research she does not pretend to have '...an objective neutral approach and indeed would question the value of having one (p.14)'. I would like to think that in common with Greed my research achieves 'subjective accuracy'.

1.5 Thesis contents

This thesis is interested to understand the ways in which speech and language therapy is marginalised. However, it is also concerned to explore both the mechanisms of this subordination and the strategies the profession has employed to overcome its marginality.

In Chapter 2 I consider the main themes relating to women's paid and unpaid work, firstly in relation to their work as a whole and secondly with regard to their roles as paid and unpaid carers. I examine these themes in order to see what light they may shed on speech and language therapists' employment. Finally, I discuss existing research on speech and language therapists' careers and consider the gaps in knowledge.

Chapter 3 aims to provide a background to looking at the role science plays in speech and language therapy in its efforts to gain credibility, a theme I address in Chapter 4. Chapter 3 begins by looking at science's main characteristics before examining sociological critiques of science. I then consider ways in which claims to scientific practice have been used to legitimise status for the health occupations. Furthermore, I consider the gendered character of these struggles, including efforts by the male-dominated medical profession to lay claim to 'science' whilst assigning female-dominated nursing work to 'caring' (with the assumption that 'caring' is of lesser value and requires little, if any, training).

Chapter 4 examines the role of science in speech and language therapy and evidence for a gender division of labour in the profession. I argue in this chapter that the profession, through its education, practice and research shapes itself unequivocally along scientific lines. Indeed, I show that the occupation has been undergoing a process of 'scientisation' in order to gain recognition. The occupational hierarchy in the profession is such that few men are to be found in hands-on practitioner roles. However, they are well-represented in the scientifically-regarded area of knowledge production.

Chapters 5 to 10 report on the face-to-face interviews carried out for this thesis. Chapter 5 addresses issues of methodology and describes the research process. I seek to justify my choice of methodology, that is, feminist interviewing and then I describe the fieldwork. Mindful of the need for a 'houseworking' of the research process (Oakley 1992), the final section contains reflexive observations on the fieldwork.

Chapters 6, 7, 8, 9 and 10 present the empirical findings of the study. These chapters follow the life-history format of the interviews beginning in Chapter 6 with a consideration of the decision-making process in research participants' choice of speech and language therapy as a career. In this chapter I illustrate, by way of the

interview data, how career choice is 'gendered' and ways in which speech and language therapy is definitely seen as a career for a girl.

Chapter 7 looks at the participants' experiences of speech and language therapy education. Through the data I show that the education focuses heavily on the acquisition of 'scientific' knowledge while paying lesser attention to its practical applications. I further show how gender stereotypes influence perceptions as to whether men are able to deal with 'emotion work'and whether women are perceived to be able to deal with the scientific aspects of the job.

Chapters 8, 9 and 10 look at speech and language therapists' work experiences. Chapter 8 examines the interviewees' work across the public/private divide. The findings indicate that speech and language therapists' careers cannot be understood without reference to wider issues affecting women's labour market position. These include the fact that on the whole women take primary responsibility for childcare and domestic labour.

In Chapter 9 I consider the status of speech and language therapy as a health care occupation. I show that the low status of the profession remains problematic and that the more powerful, male-dominated professions, medicine in particular, continue to bear an influence on its practice. Furthermore, I argue that gender is an important factor in the marginalisation of speech and language therapy.

Chapter 10 explores the role of science in speech and language therapy practice, focusing on three facets of science as applied to health care. These are that rationality is able to cure human illness, that an understanding of the parts will lead to an understanding of the whole (for example, the separation of phonetic and syntactic elements of speech) and that the object under study (that is, the patient) is better understood by preserving emotional distance.

The concluding chapter draws together the main elements of the argument and considers the usefulness of juxtaposing science and gender in explaining the marginal position of speech and language therapy.

Chapter 2

Women, work and health care

2.1 Introduction

The aim of this chapter is to examine how patterns of speech and language therapists' employment may be illuminated by an understanding of women's position in the labour market as a whole. I first consider empirical features of women's work including their participation in paid employment, their unpaid work in the home and community and women's increasing tendency to take up part-time employment. I then examine patterns of sex segregation within the labour market before looking at gender as an aspect of workplace culture. Theoretical explanations for women's position in the labour market are then examined. Given that speech and language therapy is an occupation involved in the provision of health care and in view of the fact that most therapists are female, I look at the 'gendering' in the provision of care, for example in terms of gender divisions of labour in the formal health care sector.

No attempt has so far been made to look at the gender division of labour in speech and language therapy. This thesis is the first attempt to do so. The final section of this chapter thus examines the case of speech and language therapy and considers whether there is evidence that the key features highlighted in the previous section are represented in this occupation.

2.2 Work: the public and private

There has been a major increase in the numbers of women participating in paid employment since the Second World War, so that women in the UK now constitute almost half of all employees. In March 1998 they were 49.7% of all workers (see Table 2.1).

Table 2.1 Employees in employment 1996-1998 (thousands)

	September 1996	*March 1997*	*March 1998*
Male			
Full-time	9,738.7	9,811.1	9,991.3
Part-time	1,206.5	1,265.3	1,340.3
All	10,945.2	11,076.4	11,331.6
Female			
Full-time	5,808.2	5,832.5	5,888.1
Part-time	4,897.7	5,090.5	5,290.2
All	10,705.9	10,923.0	11,178.3
% part-time			
All males	11.0	11.4	11.8
All females	45.8	46.6	47.3
% of all employees			
Males	50.6	50.3	50.3
Females	49.4	49.7	49.7

Sources : calculated from Labour Market Trends, May 1997 and July 1998.

Though women's economic activity has increased, waged work continues to be a site of considerable gender inequality, though patterns of inequality have been changing both for the better and for the worse. Feminists have drawn attention to the overriding importance of gender in the way work is structured, as Game and Pringle (1983) point out,

> Gender is fundamental to the way work is organised; and work is central in the social construction of gender' (p.14).

The gendering of the labour market affects women throughout the life course and for this reason the subject of 'women and work' has been an important focus of academics and policy makers. As Rees (1992) has pointed out:

> .....gender remains the single most important determinant of options chosen at school, industry worked in, occupation entered, amount of pay received, training opportunities received and taken up, promotion prospects, size of pension and so on. For this reason, the subject of

> women and the labour market has received considerable attention in the last decade.....(Rees 1992:2).

In addition to their paid work, women carry out the larger part of unpaid work in the home and community including child care, housework, caring for other family members[4] and other tasks within the neighbourhood. Women's unwaged work is considered by feminists to be 'work' even though it is not financially rewarded, as Witz comments, '....just because it may be done for family, friends or neighbours for no payment this does not make it any the less 'work' (p.273). Thus there is an interconnection between the nature of women's work in the 'private' sphere and that performed in the 'public' sphere, whereby the jobs they carry out for pay are often an extension of the work they perform in the home on an unpaid basis.

Another significant feature of women's paid employment since the Second World War is that of an increase in the numbers working part-time. Figures from *Labour Market Trends* (1997, 1998) indicate that the upward trend in the proportion of part-time female workers has continued in the three-year period to March 1998, with almost half of all women working in this capacity (Table 2.1). While the numbers of men working part-time have increased, their proportion of all working males is low (just under twelve per cent) and their numbers in the workforce are increasing at a slower rate than those of women. Naylor (1994) has noted that part-time working is more evenly distributed amongst all age groups of women, whereas men working part-time are more likely to be younger (particularly students) or older. Since the Equal Pay Act, the gap in pay between full-time women and men has been closing. However it diverged slightly in 1998, so that women's rates are now 80.1% of men's compared to 80.2% a year ago (Deny 1998). As regards inequalities amongst women, the pay gap between part-time and full-time women has been diverging (Walby 1997).

[4]Delphy and Leonard (1992) argue that feminists have overemphasized the work women carry out for children while underestimating the 'variety of work done by wives' for their husbands. This includes providing material support in terms of domestic labour as well as moral and psychological support. Wives may provide direct support for example as secretaries, book-keepers or shopkeepers, particularly where their husbands are self-employed.

Prior to 1995, part-timers were not entitled to employment protection rights which were normally granted to full-time workers such as maternity leave, statutory redundancy pay and the right to appeal against unfair dismissal (Employment Gazette 1995). However, this distinction was overturned in a ruling brought by the European Court in 1995. Nevertheless, this legislation has only partially improved the situation for part-time workers. Walby (1997) notes that the division between part-time and full-time work is a growing form of sex segregation in employment:

> It is extremely important in differentiating the conditions and pay of different groups of women, with the pay and conditions of full-time workers being significantly better. Its growth has implications for the structuring of employment as a whole (p.34).

The increase in part-time working has accompanied the globalisation of economic structures and the increasing casualisation of workforces. Late capitalism is characterised by expansion and investment such that monopoly corporations emerge to dominate economies on a national and increasingly international scale (Bradley 1997). The drive for economic competitiveness places pressure on local labour markets thereby increasing the need for greater casualisation and flexibilisation of labour. Walby (1997) argues that since most workers in the flexible workforce are female, 'flexibility is gendered' (p.79). The growth of flexibility has been dependent primarily on the availability of women to work part-time. This has led to a situation in which most new employment opportunities in the UK are part-time and 'for women'.

Thus women's employment has specific features which do not conform to the male career pattern. It has been argued that the latter model of career involving continuous service and steady upward promotion is generally regarded as the 'normal' career. Pascall (1994) has noted that women's withdrawal from the labour market, usually when children are born, is often followed by:

> .....a chequered pattern of part-time work, reduction in status and earning, combining paid and unpaid work roles (p.18).

Acker (1983, 1987) suggests that women teachers who follow the male career path have a 'career' while those who do not have a 'job'. Compared with the male career which involves upward movement through organisational hierarchies, women's

careers are frequently characterised by extended periods at practitioner level. Often, this is a coping strategy during periods of part-time employment (Crompton and Sanderson 1990). One last point is that the specific character of women's employment means that stereotypical views of motherhood as taking precedence lead to organisational stereotypes of women as unambitious, unreliable and lacking in occupational commitment (Lewis 1991).

2.3 The sexual division of labour

Men and women tend to be employed in different occupations and women are to be found in a much smaller range of jobs than men. Job segregation by gender, or 'the sexual division of labour' is now agreed to be the most important reason for gender inequalities in the labour market, particularly with respect to pay. Walby (1988) states that gender segregation is '.....the most important cause of the wages gap between men and women in Western economies' (p.1).

The Equal Pay Act of 1970 has provided a legal framework for establishing the comparative values of male and female work, not only in instances where a job is 'like work' in comparison with that of a man, but also where an occupation is deemed to be of *equal value*, as in the speech and language therapists' test case. However, Rees (1992) points out that the existence of gender segregation has dampened the effect of the Equal Pay legislation with limited improvement in the wages gap between men and women, in part due to the difficulty of finding male comparators. The significance of the sexual division of labour in maintaining women's unequal position in the labour market is also underlined by evidence of employers actually increasing gender divisions to avoid the threat of litigation.

Gender segregation by sex has been a remarkably persistent feature of the labour market having shown only a slight decrease in the years 1901-1971 (Hakim 1979). The sexual division of labour is characterised by horizontal and vertical segregation. In the former, women are concentrated in different areas of work, whereas in the latter they are are found in the lower rungs of the hierarchy.

In terms of horizontal segregation, a quarter of occupations are considered 'typically female', while three-quarters of occupations are 'typically male'. An analysis by Witz (1993) using data from the Census for Employment published by the Equal Opportunities Commission in 1991 showed women to be underrepresented in seven out of ten sectors of industry, including construction, energy and water and transport and communication. The three areas in which they were over-represented were: distribution, hotels and catering; banking, finance and insurance; and 'other services' including health work. Figures of employees by gender and employment for the UK in 1997 (Social Trends 1997) show that women continue to be employed in fewer industrial sectors than men. They are mainly concentrated in health and social work and the wholesale and retail sector (see Table 2.2). Men are more evenly spread across all sectors except health and education. Women, on the other hand, are severely underrepresented in agriculture, hunting and forestry, mining and quarrying, energy and water supplies, manufacturing, construction and transport, storage and communication.

Table 2.2 *Employees by gender and employment in the UK, March 1997 (thousands)*

	Male		Female	
	Full-time	*Part-time*	*Full-time*	*Part-time*
Agriculture, hunting & forestry	155.7	40.5	25.8	21.5
Mining and quarrying	52.3	1.6	7.4	1.7
Energy and water supplies	149.8	2.8	32.1	5.8
Manufacturing	2,739,5	63.4	902.2	208.4
Electricity, gas and water	97.5	1.2	24.7	4.0
Construction	670.0	11.3	91.3	43.4
Wholesale and retail	1540.5	300.9	821.1	1,117.4
Hotels and restaurants	284.9	188.8	248.2	507.6
Transport, storage and communication	918.7	56.5	268.9	83.9
Financial intermediation	443.2	14.0	425.7	129.3
Real estate, renting and business activities	1,222.9	199.0	806.1	563.3
Public administration	628.9	39.6	453.2	183.7
Education	389.1	117.1	586.5	699.5
Health and social work	358.0	112.0	928.0	1,052.5
Other community, social and personal activities	328.9	101.4	239.2	234.0

Source: Social Trends 27, Crown Copyright, 1997:76

With regard to vertical segregation, men are more likely to be found in managerial and higher professional areas of work as well as skilled manual work, whereas women predominate in lower professional and clerical non-manual work and unskilled manual work (Witz 1993). This form of segregation persists, including in male occupations to which women have now gained access. Women are less likely to occupy managerial roles and are more likely to continue in a practitioner capacity. Figures from the Hansard Commission (1990) showed that women account for 11% of general managerial staff and 25% of managerial jobs which are not in general

management. More specifically, the proportion of 'top' female managers in the NHS[5] in 1993 was 19% overall for the UK and Northern Ireland (IHSM Consultants 1994). We might expect this to be higher, given that 79% of all non-medical NHS staff are women (Department of Health 1997a).

Women also tend to work in areas regarded as less prestigious.[6] An example is that of women solicitors who now qualify in roughly equal numbers to men. While the numbers of practising female solicitors has been rising steadily, they account for only 15% of partners and tend to work in the more routine areas such as family law and wills compared with male solicitors who handle more prestigious work including criminal cases and company work. (Evetts 1994). Women solicitors are paid substantially less than their male colleagues and work mainly in smaller practices including those which do legal aid work where profits are lower. (Dyer 1997).

Job segregation occurs not only between men and women but also amongst different groups of women such that the labour market participation of lesbian and disabled women as well as those from ethnic minorities including Black and Asian women form distinctive patterns, for instance, while 20% of Asian women and 17% of white women hold professional and managerial positions, only 2% of West Indian women are likewise employed (Brown 1984, quoted in Witz 1993).

2.4 Workplace culture

Gendered divisions within the labour market are not the only source of discrimination women face in the employment stakes. Case studies have drawn attention to cultural aspects of the workplace which perpetuate the privileging of male labour above that of women, in particular ways in which the notion of 'skill' has been defined to serve men's interests. Research has also documented ways in

[5]Defined in the report by IHSM Consultants as all chief executives in purchasing authorities, provider organisations, regional health authorities, family health service authorities, blood transfusion services and regional outposts.

[6]Walby has described this shift in patriarchal strategy as one which has changed from 'exclusionary to segregationist and subordinating' (Walby 1990, p.179).

which sexuality and male power within organisations have been used to control female labour.

Numerous studies have shown that 'skill' is far from the objectively defined criterion it is commonly regarded to be, indeed, its interpretation has been shown to be fraught with gender bias. Witz states that the lower worth assigned to women's work compared to that of men's reflects 'deeply-entrenched cultural and ideological constructions' and that it is crucial to realise that the grading of jobs often depends,

> ....as much, if not more, upon the gender of the person performing it than it does on the content of the job itself' (Witz 1993:288).

It has been noted that training and ability can be overshadowed by the sex of a job's incumbent.

> ....the classification of women's jobs as unskilled and men's jobs as skilled or semi-skilled frequently bears little relation to the actual amount of training or ability required (Phillips and Taylor, 1984:55).

In a case study of whitegoods mass production plants, for example, Game and Pringle (1983) indicated that the division of labour was maintained on a series of dualisms which largely equated with masculinity and femininity. These included skilled/unskilled, heavy/light, dangerous/less dangerous and interesting/boring, the first of each pair appropriate to men and the second to women. Game and Pringle point out that 'nature' was frequently invoked in justifying women's propensity for unskilled, light, less dangerous or boring work. At the same time men's work did not require the same rationalisation, possibly because they had more power to decide which work they wanted to do or because men have 'natural' rights in the labour market. Closer inspection of the way in which these dualities operated in the work context revealed that such differences were used as a means of drawing on ethnic and sexual divisions to enhance profitability and control. Game and Pringle explain, for example, how the dangerous/less dangerous dichotomy was used arbitrarily with certain tasks regarded as more dangerous and dirty than others and a potential danger to women's capacity for reproduction, yet in whitegoods factories women often worked in dangerous, unhealthy conditions. Similarly certain kinds of work

traditionally regarded as male because of the degree of dangerousness such as enamel shop work would be carried out by migrant workers - both men and women - in other factories.

Other research has focused on the part played by sexuality in maintaining male control within the workplace. The existence of sexual harassment is now publicly acknowledged, however there is less general awareness of the broader ramifications of sexuality as applied to the workings of organisations. Burrell and Hearn (1989) point to the more or less subtle ways in which sexuality pervades the workplace, so that .

> .....the sexuality of organisations is obscured by, subordinated to or sublimated to 'non-sexual' organizational purposes (p.18).

While earlier research argued that management was concerned to desexualise the working environment in order that sex would not interfere with workforce discipline (Burrell 1984), later studies have highlighted the pervasiveness of male heterosexuality in maintaining men's power in organisational settings (Pringle 1989, Collinson and Collinson 1989, Parkin 1989). The work of Collinson and Collinson underlines the significance of traditional forms of men's sexuality in organisations which management tended '...either to be blind to, tolerate or even accept' (p.93).

Their study of sexuality within the all-male environment on the shop-floor of a lorry-producing factory, a predominantly male 'white collar' trade union and a UK insurance company with a mixed workforce, confirmed the persistence of traditional discourses surrounding male-female sexuality as exemplified by the research of Hollway (1984). For instance, men in positions of power invested in 'the male sexual drive' and 'female have/hold' discourses, in which the former assumes the male sex drive to be a natural urge attributable to biology, while the latter stresses the importance to women of marriage, monogamous relationships and the family and women as the objects of men's sexuality. Collinson and Collinson argue that this evidence illustrates how men may draw on conventional forms of masculinity and organisational power in order to 'secure themselves and their identity'. In addition

> They illustrate how the domination of men's discourses and practices about sexuality can reflect and reproduce the male-dominated nature of contemporary organizations (p.108).

2.5 Explaining women's labour market disadvantage

Explanations for women's disadvantaged position in the labour market have centred on two main theoretical concerns. The first considers whether gender inequality in paid work is a consequence of women's position in the family: the 'domestic responsibilities model' (Bruegel 1989), or whether their position in the family (being forced into marriage and dependency on men's earnings) results from women's poorer access to well-paid employment (Walby 1990). The second issue relates to the theory that patriarchal and capitalist relations have been the driving force behind the need for low-paid, gender-segregated labour.

Earlier studies on the sociology of work favoured the domestic responsibilities model whereby women's workforce position was held in large part to be a consequence of their attitudes to family and work. It was argued that female responsibilities in the home were the primary cause of women's 'problem' in relation to paid employment. (Brown 1976, Feldberg and Glen 1979). These theories left power relations within the family largely unchallenged and unquestioned. Furthermore, certain features of women's labour market patterns do not lend support to this argument. Feminists have pointed out that even when women do not take a 'career break' they are still found in low-paying jobs (Witz 1993). Additionally, since the war, the gap between women's and men's educational qualifications and labour market skills has been narrowing, a trend which has not been reflected in rising wage rates for women (Rees 1992)[7].

In the seventies, 'dual labour-market theory' sought to explain differentials between the pay and conditions of different sets of workers by suggesting that there were 'primary' and 'secondary' sectors within the labour market (Piore 1975). Workers in the primary sector had access to promotion, job security and high wages. By contrast secondary sector employees were those who received low wages, had poor career prospects and lack of job security. Barron and Norris (1976) argued that dual labour-

[7]In fact research from the USA shows that occupational differences in human capital account for less than half the gap between men and women's rates of pay (Treiman and Hartmann 1981). Walby (1990) states that this evidence 'contradicts the economic and sociological orthodoxy that women's lower wages are a result of lesser skills and labour market experience'. (p.31)

market theory could explain gender segregation at work: employers showed a preference for taking on women in secondary sector jobs because they would be more likely to accept poor pay and conditions, limited opportunities for advancement and poor worker solidarity. Men, on the other hand, were deemed more suitable for primary sector employment because they would be more inclined to seek promotions and higher salaries commonly associated with breadwinner status.

Dual labour-market theory has been criticised for its inadequacy in drawing attention to the specific ways in which women are discriminated against in the labour market, including ignoring the role union power has played in supporting men's demands in the workplace at work at the expense of women's. The theory also fails to take account of the relationship between women's work in the public sphere and that in the private domain (Rees 1992).

Marxist accounts have been used to understand structural causes of gender segregation in employment. Marx was concerned to explain class exploitation; he did not seek to account for the existence of the sexual division of labour. However, Marxist and socialist feminists have reworked Marxist theory in an attempt to do so. The 'reserve army' hypothesis is based on the Marxist idea [1867] (1954) that groups of workers (such as women) are brought in as an industrial reserve army during periods of labour shortage and economic prosperity to reduce pressure on wages. Feminists have suggested that women provide a flexible reserve army of labour because of their position in the family, particularly married women who can return back into the home once no longer needed (Beechey 1977). However the reserve army theory has been challenged by the empirical work of Bruegel (1979) who found that women were not necessarily the first to be made redundant in times of recession. Indeed, it is well-documented that women's employment has been better protected than men's in the nineties with the bulk of women's employment provided through the expanding service sector. On the other hand, men's employment has been dependent on the manufacturing industries which have seen a decline in recent years (Rees 1992, Witz 1993).

'Dual systems theory' attempts to integrate the concepts of capitalism and patriarchy in a further attempt to explain gender divisions in the labour market. Hartmann (1981, reprinted in Harding 1987) argues that is not possible to understand women's position in the labour market without considering its relationship to women's unpaid labour in the household. In Hartmann's account, both capitalism and patriarchy benefit from the institution of the heterosexual, nuclear family and from women's unpaid labour provided within it. Hartmann's work departs from other theorists in analysing not only the influence of capitalism in bringing about the gendered division of labour but also that of male power in excluding women from well-paid work.

> ....men as a group are able to maintain control of women's labour power and thus perpetuate their dominance. Their control of women's labor power is the lever that allows men to benefit from women's provision of personal and household services, including relief from child rearing and many unpleasant tasks both within and beyond households, and the arrangement of the nuclear family, based on monogamous and heterosexual marriage, is one institutional form that seems to enhance this control. Patriarchy's material base is men's control of women's labor; both in the household and in the labor market, the division of labor by gender tends to benefit men (p.114).

Walby (1986) also states that both patriarchy and capitalism operate together in the subordination of women in paid work, but in addition Walby argues that patriarchy draws on specific strategies to bar women from certain areas or to segregate them into lower graded jobs. Witz (1993) suggests that the particular contribution of the dual-systems theorists lies in the challenge they have posed to the conventional view of the family as determining women's labour market position

> The concept of patriarchy has proved vital in furthering feminist analyses of women's employment. In particular, dual-systems analyses have radically overturned the conventional view that gender divisions in employment can simply be read off from those in the family and so present a strong challenge to the 'domestic responsibilities model' of women's employment. (p.297)

2.6 Women and the provision of health care

It was seen in section 2.2 that the bulk of non-waged household work is carried out by women, including the care of children and other family members. Similarly, health care work in the public sphere is a major source of paid employment for women (see Table 2.1). This section delineates the nature of women's contribution to health care in both the private and public domains and examines the way in which

this labour may be said to be 'gendered'. Finally, it will consider the strategies men and women have used to uphold or contest the boundaries within the health division of labour.

The significance of women's role in caring for people's health in the private sphere is underlined by Doyal (1995) who states that

> Around the world the most fundamental feature of women's lives is their responsibility for home, family and household labour. Caring for and caring about others is a central feature of these activities wherever in the world they are carried out (p.22).

Marshall (1991) has shown that childcare and parenting manuals depict the ideal family as constituting a mother, father and children. While fathers are seen as important, they are not regarded as critical to the giving of daily care. Their main role is deemed to be that of financial provider. This concurs with Adrienne Rich's observation that:

> ....it is still assumed that the mother is 'with the child'. It is she, finally, who is held accountable for her children's health, the clothes they wear, their behavior at school, their intelligence and their general development (Rich 1979:53).

Recent empirical research has shown that when women return to study this has to fit in with their wife and mother roles, that is they must put their families needs before their own (Smith 1994). Similarly, research on women with careers in dual-earner households indicated that fathers did not equally share childcare and domestic tasks and support from social networks was inadequate. Many women returning to work experienced hostile attitudes from relatives, friends and colleagues at work. In their research, Brannen and Moss (1991) found that:

> .....women were forced by circumstances to rely largely on personal solutions to the demands and tensions of managing the dual earner lifestyle, which fell largely upon them (p.252).

Though there is some evidence for a lessening gap between the proportion of domestic labour contributed by women and that contributed by men, evidence of a more equitable division of labour in homes where women work full-time (Graham 1993), of significant numbers of older men caring for their spouses (Arber and Ginn 1990) and class and race differences in the extent of people's caring responsibilities

for others (Graham 1993), women still retain the primary responsibility for household work (Pahl 1984, Delphy and Leonard 1992, Rees 1992, Thomas 1995). This is true not only in the 'developed' countries; Shiva (1993) refers to women's labour in the global context as 'social labour' which is defined by industrialisation as 'non-labour' on account of its association with women's 'natural' propensities. Importantly, women's labour is seen as 'non-labour' because it is not available for exchange on the market and it is performed unpaid within the institution of marriage and the family. Empirical evidence supports this. Delphy and Leonard point out that the time women spend on domestic work has not declined this century despite the advent of the so-called 'labour-saving' devices and that women do twice as much domestic work as men each day.

Feminists have drawn attention to the key importance of this labour to people's health and well-being by making visible 'the distinctive labour of women' (Rose 1994:37). In a paper examining the relationship between unpaid domestic labour and health, Thomas (1995) states that women's domestic labour is '.....fundamental to the production and reproduction of 'the body'.....'(pp. 328-329). Thomas points out that domestic labour was a vital factor in the fall in mortality rates in the late nineteenth and early twentieth century, an issue overlooked in the more widely accepted theory which links improvements in the population's health with better material standards of living (McKeown 1979).[8] Historically, poor working conditions associated with early industrialisation precipitated chronic ill-health amongst the working population. The state legislated to curtail female and child labour and shorten the working week. There was a concurrent shift of labour from the public to the private sphere creating a division of labour between the male 'breadwinner' and female 'housewife'. Thus women's domestic labour was harnessed to the benefit of industrialisation. As Thomas has shown, this includes the maintenance of the health of the family and housework.

[8]Thomas (1995) reviews reasons posited for the omission of the relationship between domestic labour and health in sociology, firstly that male-oriented social science has kept female spheres 'hidden' from history or secondly, that this oversight is a consequence of an obsession with waged work under capitalism which obscures the role of unpaid work including domestic labour.

Going beyond the traditional biomedical concept of health as absence of disease, Stacey (1988) defines health work as activity which encompasses the production and maintenance of health, the restoration of health, the care and control of birth, mating and death, the amelioration of untreatable conditions and the care of dependants. This includes domestic work involving birth and the rearing of children, looking after our bodies, retrieving and preparing food, and cleansing and caring for members of the household. Graham (1985) specifies women's essential contribution to the health of the family as

> .....providing for health, teaching for health and, in times of crisis, mediating professional health (Graham 1985:26).

Providing for health, for instance, involves the provision of a warm, clean home, a nutritionally-balanced diet and a socially-conducive environment which minimises

> ....the health-damaging insecurities and anxieties which can arise when these relations go awry (Graham 1985:26).

Graham's work, along with others (Finch and Groves 1980) is significant in that it redefined domestic labour as 'caring' work encompassing the affective as well as the material aspects of women's labour, that is work which involves both 'labour' and 'love'. Oakley (1993) has also underlined the importance of emotional support in women's 'housework'

> To call women's household health work by the name of 'housework' is to ignore an extremely important aspect of the domestic division of labour, and that is women's role as the chief managers of personal relations both inside and outside the family. Emotional support promotes health: there is good evidence that a person's social relationships or lack of them are crucial influences on physical and mental functioning. As family welfare workers - as mothers, mothers-in-law, wives, housewives, sisters and daughters, and often neighbours as well - women take care of personal relations (p.5).

Having discussed 'informal' health work in the family, I now turn to women's health work in the public sphere. The significance of women's labour in the formal sector of health care work is evident from NHS workforce statistics. In the UK 79% of NHS staffing is made up of women (Department of Health 1997a), a proportion unchanged in the last six years (Equal Opportunities Commission 1991). The division of labour present within the NHS mirrors that found in other spheres of paid employment, namely that of women's overrepresentation in the less prestigious, lower paid

occupations and underrepresentation in areas of high status and high financial reward. Table 2.3 shows that women form the larger percentage of workers in all the 'caring' functions of the NHS, in particular those areas involving direct contact with the public, including nursing, the professions allied to medicine and healthcare assistants. They make up a smaller proportion of scientific and technical and administrative staff.

Table 2.3 *NHS Hospital and community health services: Non-medical staff by sex, England as at 30 September 1996 (whole-time equivalents)*

	Total	Male(%)	Female(%)
Nursing, midwifery and health visiting	332,660	11.5	88.5
Qualified staff	248,070	11.1	88.9
Unqualified staff	83,650	12.6	87.4
Learners	2,670	5.1	94.9
Scientific, therapeutic and technical staff[9]	99,030	25.7	74.3
Professions allied to medicine	42,460	13.5	86.5
Other scientific, therapeutic & technical	56,560	34.9	65.1
Healthcare assistants	16,790	17.9	82.1
Support staff[10]	70,140	34.6	65.4
Ambulance staff	15,110	78.4	21.6
Administration and estates staff[11]	167,430	26.1	73.9
Administrative managers	20,590	48.5	51.5
Clerical and administrative staff	132,290	15.0	85.0
Other staff	3,180	22.2	77.8

Source: Department of Health Statistical Bulletin, Crown Copyright 1997, Table 7.

In terms of participation in medicine, the profession with the highest remuneration and arguably the greatest prestige in health care, women are entering medical school in greater numbers than ever before, although vertical segregation continues. In 1990 women still made up only 25.2% of practitioner posts in general practice (Allen 1992). In 1995, 19% of hospital consultants were female (Department of Health

[9] Scientific, therapeutic and technical staff – these pertain to more than 21 categories of staff including dietetics, chiropody, speech and language therapy, radiography, clinical psychology, medical physics, pharmacy and dental.

[10] Support staff pertain to ancillary staff.

[11] Administration and estates staff – these include general and senior managers, and clerical and administrative staff, maintenance and works staff.

1996). However, both these figures represent an upward trend on previous years, a phenomenon which has been noted in other countries (Notzer and Brown 1995).

Within medicine, gender segregation is also evident. Looking at gender divisions in medicine Oakley (1993) notes that

> .....we not surprisingly learn that women specialize in areas to do with children, mental illness, microbiology (perhaps a form of housework carried into the hospital setting?) and putting people to sleep, otherwise known as anaesthetics (p.6).

Recent figures for the NHS indicate that by 1995 women's numbers as consultants and senior registrars in paediatrics and psychiatry were continuing to increase, but that in surgery they were still a minority (Department of Health 1996). Notzer and Brown (1995) cite evidence to suggest that men choose medical specialities which are fitted to 'typically' masculine traits

> .....men have preferred the surgical specialities because of their attraction to working with instruments and managing 'dramatic' situations (p.378).

However, factors other than 'choice' have been shown to come into play, underlined by evidence that female doctors are more likely to be dissatisfied with the career opportunities which are available to them (Elston 1980).

Nicolson (1992) has highlighted vertical segregation in clinical psychology so that women outnumber men at the lower status, low-paid end of the occupation with few present in Top Grade posts. This is in spite of an increase in the numbers of women qualifying as clinical psychologists and the concomitant expectation that they would achieve seniority in equal proportions to men. Nicolson points out that men receive distinguished contributions and awards in greater numbers than women, they dominate academia in both the USA and the UK and they occupy the majority of committee places in professional organisations such as the British Psychological Society. Nicolson depressingly states that '.....psychology remains, and is likely to remain, male dominated' (p.23).

She further notes horizontal segregation in the profession. Women tend to be found in the applied areas of psychology, particularly in non-managerial positions, whereas

the 'scientific' arm of clinical psychology is associated with men's work in the profession.

> Applications of the discipline (which are female dominated in numbers but male dominated in terms of power positions) seem to have lower status and although it is clinical and educational/child psychology that attract public attention and put theory into practical use, the power attributed to applied psychology falls short of the more overtly high status professions (for example, medicine) which are male-dominated. When there is a hint that a profession is helping rather than scientific, then it is both lower status and appealing to women (p.25).

The role of science in upholding the division of labour which equates masculinity with science and caring/helping with femininity will be taken up again in the next chapter.

Cockburn (1985) has noted vertical segregation in radiography. Men tend to enter diagnostic rather than therapeutic radiography, since the former has more opportunities for career development and is less nursing-oriented.

> In disproportionate numbers men float rapidly upward to the top of the profession helped by their freedom from day-to-day domestic responsibility (p.128).

Echoing the above observations made about clinical psychology, Cockburn points out that in 1980 the president, the secretary and more than half of the professional body's council were made up of men, a disproportionate number held superintendent posts in hospital departments and they were more likely to seek opportunities in teaching, research and overseas and in sales of X-ray machinery. The stereotype of the male disdain for emotional involvement was held up as a reason for their career ambition,

> 'Anything', say some of their women colleagues, 'to avoid being there when someone is weeping or throwing up' (quoted in Cockburn 1985:128).

Aside from gendered expectations of greater ambition amongst male radiographers was a perception of their greater technological competence, as one man suggested,

> 'I think if there was a new machine that none of us had seen before, I probably would pick it up quicker. Because I've always had a bit of an aptitude for making machines work' (quoted in Cockburn 1985:131).

Cockburn suggests that young men encounter, '.....a widespread ideology that defines them as being unable or unwilling to take on the caring role in the hospital' (p.138). Men were, according to one study participant,

> '....more willing to give up contact with patients and people in order to do a job which makes them feel, I don't know, more intelligent' (p.138).

On the other hand, some people questioned gendered stereotypes, including one woman radiographer who explained that:

> The men often do appear to be more interested in the technological side but I'm not sure whether that is because they think they are supposed to be or because they genuinely are....The over-riding feelings of society, that it's not man's work, tends to affect what men think about radiography and how they approach it. It may well *make* them more interested in the technical side rather than the caring side (p.139).

Finally, the case of pharmacy serves to underline the issues raised for medicine, clinical psychology and radiography. Pharmacy is currently 'feminising', with half of all graduating pharmacists now female (Wallis 1996). According to its professional body, pharmacy appeals to women because it affords them the opportunity to return to work to the same job after having children and because of the availability of locum work (which presumably they can 'fit' around the wife and mother role). Another attraction for women is believed to be that pharmacy is a 'caring' profession, as the head of education at the Royal Pharmaceutical Society said,

> Hospital pharmacists are moving out of the dispensary and into the ward and their communication with patients is everything. We tend to find more white females in hospital pharmacy than other groups....(p.3).

Wallis draws attention to the fact that there is currently a shortage of pharmacists and a greater need for locums. Also, she notes that hospital pharmacists earn considerably less than their counterparts in industry. The article conveys the notion that women 'choose' their conditions of work including flexible hours and more face-to-face contact with patients in hospital work. The question then arises as to whether real choices are being made available to women, or whether vertical segregation is operating within the pharmacy labour market reserving the highly-paid, prestigious work for men while relegating women to the lower paid, practitioner niches within the profession.

2.7 Boundaries of professional power

The last part of this section examines the health occupations in terms of struggles undertaken to contest or maintain the boundaries within the health division of labour. The importance of professional power as a site of conflict in health care is apparent from the subject's prominence in the sociology and nursing literature from the late 1970's onwards (Gamarnikow 1978, Salvage 1985, Salvage 1988, Witz 1992, Witz 1994, Walby and Greenwell 1994, Davies 1995, Cant and Sharma 1995). First, this section briefly considers earlier work on the sociology of the professions which underpins much of the subsequent work on the health professions. It then examines the ways in which this has been applied to health occupations looking at accounts which have analysed shifting professional boundaries, in particular the ways in which the lower status professions have sought to move up the occupational hierarchy by means of 'professionalisation'.

The question of what constitutes a profession has been much debated. Numerous attempts have been made to identify the key characteristics which define a job as a profession (Williams 1993). Friedson (1986) stresses that central to the idea of 'profession' is the notion of autonomy, the possession of which implies a profession is able to regulate its own affairs, an ability which is statutorily granted. Citing work by Millerson (1964) who attempted to draw out a definition of the professions based on a number of authors, Williams outlines six of the main characteristics: skill based on theoretical knowledge, the provision of training and occupation, tests of the competence of members, organisation, adherence to a professional code of conduct and altruistic service. A key element of the relationship between client and professional is that of 'mystification',

> .....professionals promote their services as esoteric. They create dependence on their skills and reduce the areas of knowledge and experience they have in common with clients. In this way they increase the 'social distance' between themselves and their clients and so gain increasing autonomy (Williams 1993:8-9).

An important characteristic is that of a body of theoretical knowledge which forms the basis for applied skills, as Walby and Greenwell (1994) have succinctly put it:

> One source of variance was whether the distinctive knowledge base of professions was seen as so theoretical, scientific or complex that it generated an indeterminacy which meant that only the fully trained professional could really be competent in a given sphere, or whether it was a set of technical rules to be learnt (p.59).

As Williams (1993) points out, the traditional professions including law, medicine and architecture have well-established knowledge bases of expert knowledge which provide the foundations on which professional status rests, such that, '.....the purveying of that knowledge is the means by which power and control are maintained' (p.9).

Of concern within the literature on the professions has been that of the mechanism by which occupations seek recognition through the process of professionalisation and more recently how the so-called 'semi-professions' (Etzioni 1969) including nursing, midwifery and social work have pursued this path towards enhancing their status. Another area of debate refers to whether medicine is currently undergoing the reverse process of 'deprofessionalisation' (Elston 1991). Since nursing has been the subject of considerable interest from this point of view, a consideration of historical and contemporary trends pertaining to this occupation is warranted.

Many writers have examined the trend in nursing towards professionalisation including the strategies nursing has used in pursuing this, the political context in which professionalisation has taken place and the implications of professionalism for nursing practice (Salvage 1985, Salvage 1988, Witz 1992, Soothill *et al* 1992, Witz 1994, Walby and Greenwell 1994, Davies 1995). Much of this discussion relates to the nature of the division of labour between nursing and medicine, the extent to which nursing reforms pose a threat to medical dominance and the consequences of this for patient care. Witz (1994) proposes a framework encompassing four elements to analyse the professionalisation of nursing including that of grounding nursing reforms historically and examining the influence of medical control, gender and health policy on the profession. Witz argues that the advent of *Project 2000* which sought to free nurse education from service needs, did not represent a radical break

from the past given much earlier attempts by nurses to oppose attempts to control and limit their education[12].

On the other hand, *Project 2000* pays more attention to nursing practice than earlier reforms, in particular in advocating greater practitioner autonomy. However, Davies (1995) points out that political expediency to provide sufficient 'pairs of hands' and the perceived threat to doctors from educational reform in nursing has meant that the reforms, though effective in bringing about changes in nursing education, have had little influence on practice. In considering the extent to which *Project 2000* was an affirmation of the worth of nursing she states:

> To the doctors, some of them at least, it was the reverse. Nurses were getting above their station. The politicians presented no such direct challenge, and by implication it seemed that the nurses' case had been accepted by them. The nature and level of the support that nurses received however, made one thing abundantly clear. Staffing the service takes precedence over educating the nurse (p.126).

In terms of nursing's threat to medical dominance, Witz is cautious arguing that this depends on political reforms in the 1990's as well as the shifting of occupational boundaries. Witz maintains that medicine may play a critical part in the development of nursing directly by opposing or supporting changes or indirectly in response to government health policy. Medicine's response to *Project 2000,* for instance, was less than supportive, with the medical press arguing that medicine was essentially science-based and that nursing aimed to improve the comfort of the patient (Davies 1995). The significance of science in maintaining and contesting the health division of labour will be taken up again in Chapter 3. Some writers suggest that the nursing challenge is considerable owing to the new nursing discourse around the care/cure dichotomy (Beardshaw and Robinson 1990, Davies 1995). Davies, for instance, highlights the ways in which the 'old professionalism' (p.135) to which medicine clings may be antithetical to patient care. Any challenge to this is, however, circumscribed by the gendered nature of the health division of labour. She argues that the traditional model of professionalism is essentially masculine, emphasising distance, autonomy, self-orientation, mastery over knowledge and instrumentality

[12]For example, nurses' opposition to the Hospital Association's attempt to limit nursing education at the turn of the century (Witz 1994).

over decision-making. The adoption of the opposing qualities of engagement, interdependence, reflective practice and partnership may conflict with nursing's attempt to gain greater recognition and status, thereby locking nursing '....further into the devaluation it already experiences by association with women's work' (Davies 1995:152).

The health reforms of the eighties and nineties culminating in the creation of the NHS internal market (Department of Health 1989a) have led to a mix of consequences for nursing. Witz has noted that while the shift of emphasis towards community care provides nursing with increased opportunities to implement the new nursing philosophy, GP control has been established over purchasing decisions via fundholding and multifund commissioning. It remains to be seen how recent recommendations made in the recent White Paper *The New NHS* (Department of Health 1997b) will influence the position of nursing in relation to medicine. Of interest in this regard are the Primary Care Groups composed of both GPs and community nurses in place of fund-holding and NHS Direct, staffed entirely by nurses.

2.8 The case of speech and language therapy

Placed in the context of the discussion in sections 2.2 to 2.7 it might be expected that as an overwhelmingly female profession, particularly at practitioner level, speech and language therapy would be subject to many issues facing women in other spheres of employment including part-time working, non-linear career paths, attrition, marginalisation and low pay relative to the level of training required. I will take up the issue of job segregation in Chapter 4.

The implications of part-time working for speech and language therapists were touched on in Bebbington's (1995) study. There was evidence to suggest that the availabilty of flexible working patterns was a factor in keeping therapists in the profession. On the other hand, it appeared that career opportunities for part-timers may be limited. There have been no attempts to systematically quantify the numbers

of part-time speech and language therapists in the workforce, nor have there been any efforts to look at the effect of this pattern on career opportunities, career progression and pay.

Speech and language therapists' career progression has not been studied in depth, for example, via longitudinal research or cohort studies. However, it might be expected that, given the preponderance of women, their careers would not conform to the linear path which characterise men's careers (see section 2.2). Bebbington's (1995) research did describe an example in which a female therapist's career was interrupted because of family demands, in this instance, on account of her partners' need for mobility, as the therapist explained:

> I certainly haven't got a career progression. I've never had that with a husband whose work has meant constantly moving. You just have to take whatever job comes up and sometimes you're lucky and sometimes you're not. You stick with it until you move again. So I've never done the thing of *I'm not statisfied with this job, I'll go and find another one.*

Several reports commissioned by the government (Quirk 1972, Manpower Planning Advisory Group 1991) and the Royal College of Speech and Language Therapists (Bebbington 1995) have drawn attention to the problem of attrition. These reports have been limited in their attempts to draw on theoretical explanations for this problem. Quirk (1972), in attempting to explain why most therapists gave only 3-5 years' service, drew on the 'domestic responsibilities model' to explain why therapists left following only a short time practising, commenting that there was:

> ....no doubt that the major immediate cause of the early losses is the effect on a predominantly female profession of the trend to earlier marriage (p.49).

The report felt that the solution lay in providing better support and encouragement, improved working conditions and enhanced status to attract married women with children back into the profession. Government statistics including those published by the Manpower Advisory Group provided valuable empirical data on patterns of recruitment and retention, but were circumspect as regards the reasons behind attrition, also tending to regard motherhood as the problem,

> In a predominantly female profession, the fact that such a large proportion of speech therapists are so young makes the service vulnerable to severe maternity leave disruption (MPAG 1991:1).

The marginalisation and undervaluing of speech and language therapy has been a constant theme in the professional literature, though not a subject deemed worthy of in-depth academic study. These accounts highlight worries over pay and conditions and ignorance of both the training and scope of speech and language therapy both on the part of the public and other health professionals. This theme is traceable from the Second World War to recent concerns expressed in the *Bulletin.*

Reports published during and just after the Second World War spoke of the conditions of work in which speech and language therapy operated. These included the problem of the demand for therapists exceeding supply (Board of Registration of Medical Auxiliaries 1944), the lack of knowledge of the work generally, the indifference of the medical profession to the profession's work (College of Speech Therapists 1945) and the fact that prior to the establishment of the NHS hospital therapists often worked for no pay (Robertson et al 1995), a practice the Board of Registration of Medical Auxiliaries recommended abolishing.

Some twenty-five years later, sixty years after speech therapy's initial inception, it was evident that the occupation had not attained, in the opinion of the Quirk Committee (Quirk 1972), 'a strong professional position' (p.1), noting a marked contrast:

> ....between the value attached to the speech therapist's work and the ignorance, in many quarters, of the complexity, range and difficulty of that work; between the eagerness of employers to recruit speech therapists and the poor working conditions offered; between the readiness to enlist the speech therapist's help and the reluctance, in some professions, to accept her as a colleague upon equal terms (p.1).

The report concluded that the scope and competency of speech and language therapy was not fully appreciated either by the public or fellow professionals. Based on these findings, a number of far-reaching recommendations were made including the uniting of speech and language therapists working in education and health under the umbrella of the Area Health Authorities, improvements in working conditions, better representation at the higher levels of the Department of Health and Social Security, a move towards an all-graduate portal of entry and the establishment of registration to practise.

Despite the credentialist strategy which secured speech and language therapy as an all-graduate profession by 1985 (though registration continues to be non-statutory), the eighties and nineties have continued to see dissatisfaction expressed over pay and conditions and concern with lack of recognition of the scope of the work (Bebbington 1995). Furthermore, calls have been made to introduce non-managerial supervision in order to help retain staff (Green 1995). In spite of a victory for several of the Equal Pay test cases after an eleven-year court case, changes to the pay and career structure of the profession have yet to be made. In fact a recent letter to the *Bulletin* indicated concern that the winning of the Equal Pay case has not translated into pay increases for speech and language therapists across the board (Doherty 1999).

Aside from references to the Equal Pay case on the literature on professional women's careers (Shrubsall 1994), speech and language therapy is largely invisible as a topic of sociological interest. Much of the sociological research, as was seen in the foregoing review of the literature (see sections 2.6 and 2.7), focuses on medicine and nursing, especially in their occupational relationship within the acute health care sector. There have been no attempts to consider the professionalisation strategies of speech and language therapy in and of themselves or with regard to how these have been received by other health professions, particularly medicine. The absence of speech and language therapy within this body of work might constitute a further indication of the profession's marginality within the NHS.

2.9 Summary

This chapter has highlighted a number of themes pertaining to women and work - the relationship between paid and unpaid work, the propensity in the UK for women to work part-time, the difficulty of conceptualising women's careers in terms of a linear career path and the gender-segregated nature of the labour market. More recent theorising on women's employment points to the significance of both patriarchy and capitalism in controlling female labour both inside and outside the home.

I have also drawn attention to the point that the provision of health care in both the public and private spheres continues to be a largely female domain. I emphasised, however, that this work is often 'invisible' even though it may be critical to human survival. A gender divide exists in the area of paid health care in which women continue to occupy the less prestigious jobs. More specifically, men tend to occupy the 'scientific' and managerial functions within the professions while women remain in hands-on practitioner roles. Status in health care work is thus frequently associated with men's 'scientific' and managerial work while women's contribution is seen as 'natural' or 'unscientific'; the low status end of health care. I have also shown that the health occupations have the same gendered characteristics as all other occupations, including patterns of horizontal and vertical segregation.

I have indicated that there is a dearth of empirical and theoretical work focusing on speech and language therapists' experiences of the labour market, although a number of reports have pointed to certain problematic areas. In the next chapter I set the scene for exploring the work of speech and language therapists by reviewing existing research on science and the health division of labour. Chapter 4 is concerned specifically with the role of science in speech and language therapy.

Chapter 3

Science and the health division of labour

3.1 Introduction

Chapters 1 and 2 pointed to the lower worth assigned to speech and language therapy in comparison with male-dominated forms of health care work, including medicine, although medicine is increasingly feminised. In addition, it was seen that men's health care work tends to be regarded as scientific in contrast to women's caring work which is often perceived as unscientific.

This chapter provides the background for examining the role of science in speech and language therapy by looking at the function of science in the health division of labour as a whole. While no literature has examined this theme in speech and language therapy, research has considered the significance of science in other areas of health care. I examine the issue of whether science is a value-neutral activity or whether in fact scientific practices in health care may be to a greater or lesser extent politically constituted. I begin by examining meanings of science within a historical context. I then move on to look at critiques of science. The role of science in health care is then examined before considering the significance of science in gendered occupational struggles. The rationale for looking at science is to see whether such an analysis may shed light on speech and language therapy (see Chapter 4).

3.2 Characteristics associated with science

In this section I firstly consider the characteristics generally associated with science. I then develop this characterisation by means of a brief overview of the history of science. Finally, I point to the influence of science on the newer academic discplines,

in particular linguistics and psychology, key components of the speech and language therapy curriculum.

Science, according to the dictionary definition, is

> .....a branch of knowledge dealing with objects, forces and phenomena of the natural universe based on systematic observation of facts and seeking to formulate general explanatory laws (quoted in Cameron 1985:19).

One of the important characteristics of science, as opposed to other types of study, is the idea that science deals with 'facts' rather than opinions or values. In relation to value or opinion science is neutral or free of values, 'ideologically pure, value-free' (Rose 1994:7), a claim which has come under increasing scrutiny as will be seen in section 3.3. Scientific endeavour is held to be objective and methodical, seeking not only to uncover factual knowledge but also to look for the causes which underlie the facts. Another important feature of science is the status accorded to it through its use of logical deduction and objectivity. The standing of science is such that, 'We tend to believe that science is the key to truth' (Cameron 1985:20).

Modern scientific thinking is commonly associated with historical developments around the seventeenth century, the age of the Enlightenment. Slow changes in the millenia prior to the fifteenth century gave way to a rapid succession of developments in science and technology in Western Europe. The rise of science occurred concurrently with a decline in feudal society and the beginnings of capitalism, economic growth fuelling the need for technology. The importance of science was symbolised by the creation in the seventeenth century of a number of European scientific academies (Rose and Rose 1969). Deborah Lupton, in examining the influence of Enlightenment thought on the public health movement (Lupton 1995), describes the era from the end of the seventeenth century until the late eighteenth century as

> ...a reaction against unquestioning religious and superstitious belief, and a strong optimism in the ability of humans to control their destiny to their own convenience. It was believed that nature was patterned and predictable, and that its laws could be discovered using human insight. The uncovering of truth using rational thought, scientific method, experiment and calculation was believed to be the key to human progress (Lupton 1995:21).

Summarising the work of postmodern critiques of the Enlightenment, Flax (1990) points to a number of themes characterising the project of this movement.These include a notion of truth which is believed to mean

> .....something 'real' and unchanging (universal) about our minds or the structure of the natural world (p.30).

Importantly, this reality exists independently of the knower and is not created or transformed by the mind or by the process of knowing. Furthermore, there is a belief in the idea that knowledge used by those with legitimate power will lead to freedom and progress, that this knowledge is neutral and will be beneficial to society. Another aspect is that science is perceived as an activity towards progress; it acquires knowledge of the 'real' world, and as this accumulates it becomes progressively more accurate and encompassing. Much of Enlightenment philosophy centres on the rationality of the human subject,

> Humans are said to be intrinsically good, able to reason and to be rationally governed. Goodness will naturally unfold and be expressed as people's external circumstances become more favourable....(p.31).

Feminist critics of science challenge the themes of rationality and detachment and the separation of the 'knower' from the 'known'. According to Keller in her essay, *Reflections on Gender and Science* (Keller 1985), the ideology of science is an 'objectivist illusion' in which the self is reflected back as 'autonomous' and 'objectified' (p.70); the scientist is cut off from external objects and his subjective self. Keller believes that modern man is constituted by detachment and impersonality, and the '.....claim to have escaped the influence of desires, wishes and beliefs.....'(p.70). Bordo (1986) states that Descartes' legacy to modern science, of which he is widely regarded the father, is based on the themes of detachment, dispassion and clarity. She points out that during the Renaissance mental life became characterised by philosophers as an inner space which could be reflected on. Descartes' model of knowledge, influential to science and subsequent philosophers, centred in *Meditation 2* on:

> 'whether any of the objects of which I have ideas within me exist outside of me' (Descartes in Halden and Ross 1961, quoted in Bordo (1986).

In this situation, *'cogito ergo sum'* is the only reality,

> ....for to be assured of its truth, we require nothing but confrontation with the inner stream itself (p.443).

Indeed, Cartesian thought contrasted with Medieval and Greek philosophy in which 'inner' and 'outer' were not separated; there was no concern to locate human reason within one or the other.

The discourse of mathematics was an important element in the emerging scientific culture of the seventeenth century (Bordo 1986), as Woolf (1961, quoted in Hughes 1995) observed,

> Measurement has long been considered a hallmark of science properly practised, and once a new discipline has developed a mathematical discourse, it has almost immediately laid claim, at least in the language of the most enthusiastic disciples to the significant status - science! (p.3).

Hughes (1995) has documented that the principles of probability and descriptive statistics have long been used by science, but that the development of statistical mathematics was a nineteenth-century invention, an early proponent being Francis Galton. Significantly, the application of statistics meant that the previously descriptive science of biology was now amenable to mathematical analysis. In contemporary science Hughes notes that statistical analysis is used by all natural and social scientific disciplines, which when incorporated into the scientific method (as the positivists argue) is sufficient to overcome social and political subjectivity. The importance of statistics to the history of the scientific method is underlined by the fact that the chi-square test is listed as one of twenty most important scientific breakthroughs this century (Hughes 1995). The claim to power of statistics is exemplified by the words of Galton (quoted in Hughes, p.395)

> Some people hate the very name statistics, but I find them full of beauty and interest. Whenever they are not brutalized, but delicately handled by the higher methods, and are warily interpreted, their power of dealing with complicated phenomena is extraordinary. They are the only tools by which an opening can be cut through the formidable thicket of difficulties that bars the path of those who pursue the Science of Man (Natural Inheritance, Galton 1889).

A further characteristic of modern science is that of the reductionist paradigm, also associated with the Scientific Revolution (Shiva 1993). Reductionism assumes that the causes giving rise to an event are determined by breaking it down into its component parts and examining the interrelationship between these parts. Shiva, in her analysis of the effects of modern science on ecosystems, suggests that the epistemological assumptions of reductionism are based on

> ....uniformity, perceiving all systems as comprising the same basic constituents, discrete, atomistic, and assuming all basic processes to be mechanical (p.23)

and later, '..uniformity permits knowledge of parts of a system to stand for knowledge of the whole' (p.24).

Impressed by the prestige which science has accrued, some of the newer academic disciplines have adopted its philosophy and methods. Psychology and linguistics, for instance, have striven towards acquiring 'factual' knowledge via experimental methods and a reductionist approach. Sherif (1987), for example, has highlighted the tendency of psychology to follow experimental methods in research design. The scientific approach is most clearly epitomised in the psychology experiment in which parts or 'variables' are isolated and their relationship or 'correlation' studied, as Sherif explains:

> The methodology promoted in psychology, in its strivings for social acceptability and prestige, rested on the assumption that the causes of an event can be determined by breaking down the event into component parts, or elements and studying those parts and their relationship to one another. The more 'basic' these parts or elements are, the more 'basic' the inquiry (p.43).

Th reductionist idea of breaking down a phenomenon into its component parts in order to understand the whole is a feature of structural linguistics. A common method of analysing language, for example, is to obtain a corpus of data and to derive from this an inventory of words, sounds and syntactic forms (Cameron 1985).

3.3 Critiques of science

This section begins by considering the mounting critique of science which began primarily in the sixties and continues to the present day. There follows a

consideration of the political aspects of scientific development, ending with an overview of the feminist critique of science.

The post-war period from the mid-forties until the mid-sixties saw a period of deference towards science on the part of the public. Durant (1998) points out that:

> The period from 1945 to 1965 was the heyday of deference to the scientific expert. He (it was almost always he) was the architect of astonishing new discoveries - jet-powered aircraft, atomic power, antibiotics - which were bound to make the world a better place (p.71).

Since the mid-sixties, however, there has been growing scepticism over the extent to which science is considered a force for 'good'. A major criticism concerns science's claim to be a mode of inquiry which is free of values. If value-neutrality is questionable this leads to questioning as to whether science can approximate the 'truth' or 'facts' about a given phenomenon. Commentators from the early sixties to the present day have argued that science as an activity cannot be divorced from its wider cultural context, as Rose and Rose (1969) have pointed out,

> .....much of our modern science has been shaped by the requirements and constraints placed upon it by the society in which it is performed. It is this integration which makes fallacious any attempt to describe science as some sort of external agent acting upon a society and thus transforming it...(p.240).

Kuhn's *The Structure of Scientific Revolutions* (1962) posited a major challenge to the idea of science as an autonomous, progressive activity seen to lead to ever greater approximations towards reality. Kuhn's work was important in showing via the use of examples drawn from the history of science, that scientific revolutions do not occur systematically through a mechanism of internal logic. On the contrary, new 'paradigms' - defined as:

> ...universally recognized scientific achievements that for a time provide model problems and solutions to a community of practitioners' (Kuhn 1962:viii)

take place within a community of scientists, the operation of which influences the path of scientific progress. Among these influences is the likelihood that a group of scientists will select problems for which they believe there is a solution. They may

reject problems which are deemed to be metaphysical in nature, belong to another discipline, 'are just too problematic to be worth the time' (p.37) or which cannot be conceptualised using the paradigms available, as Kuhn states:

> One of the reasons why normal science seems to progress so rapidly is that its practitioners concentrate on problems that only their own lack of ingenuity should keep them from solving (p.37).

Since Kuhn there has been growing disillusionment with science as an agent of change in society leading to ever closer approximations to 'the truth'. Sociologists and philosophers of science have analysed the assumptions of the scientific method and its implications for society (Rose and Rose 1969, Ravetz 1971, Latour and Woolgar 1979, Gilbert and Mulkay 1984). There also exists a considerable feminist critique of the 'gendering' of science (Keller 1985, Harding 1986, Kirkup and Keller 1992, Rose 1994). Most recently, Beck (1992) has posited the notion of 'risk society' in which scientific developments are put in train without knowledge of the consequences. Where pre-industrially disasters were attributable to natural occurrences or put down to 'fate', modern-day risks are increasingly created out of scientific developments. Levels of risk are becoming more difficult to assess because the consequences created by nuclear power, chemical and genetic developments and ecological hazards are unknowable. This leads to increasing anxiety which is coupled with decreasing faith in scientific expertise, such that there is scepticism, people having '....moved beyond the time when scientists in white coats could be trusted' (Franklin, p.5). With regard to the ecological crisis Beck has said that:

> .....under the impact of modern risks and manufactured uncertainties, these modes of determining and perceiving risk, attributing causality and allocating compensation have irreversibly broken down, throwing the function and legitimacy of modern bureaucracies, states, economies and science into question. Risks that were calculable under industrial society become incalculable and unpredictable in the risk society (p.16).

Thus the power of science for the human good is now seriously challenged; while science may be an asset, public confidence in scientific knowledge has been severely challenged. A significant driving force behind the earlier critique of science was opposition to the use of science for militaristic purposes, in particular, nuclear weapons. Yet despite public concern, the political motivation of scientific 'progress'

remains clear - over half the UK science budget is allocated to military purposes (Rose 1994). A further factor is economic growth, for instance, it has been argued that multinational corporations have harnessed science to boost their profits (Mies and Shiva 1993).

Feminists have theorised that science is integral not only to systems of late capitalist domination but also to patriarchy (Rose 1994). This critique has focused on unravelling its sexist bias, including the gendering of scientific knowledge, the biologism of science in 'accounting' for female behaviour and the exclusion of women from scientific activity. A major theoretical development was the work of Evelyn Fox Keller (1985) which highlighted not only the exclusion of women from science, but also the gendered character of its origins. Keller based her thesis on the commonly-held belief in which: '...objectivity, reason and mind are cast as male, and subjectivity, feeling, and nature as female' (p.7).This mythology is reflected in the works of Plato and Bacon, early forefathers of modern science. Keller shows that the language used in these philosophies is steeped in misogynist imagery which casts nature as female and mind as male. The philosophy sought was a masculine one which could be

> .....distinguished from its ineffective predecessors by its 'virile' power, its capacity to bind Nature to man's service and make her his slave (Bacon)' (p.7).

With regard to female personality traits, modern science has perpetuated a long history of defining femininity in relation to masculinity according to various bipolar traits. Psychological research in the more recent history of science has similarly carried forward the notion of biologically-related gender differences by posing questions to 'prove', for instance, that boys are more aggressive than girls or that girls prefer to play with dolls. Furthermore, psychologists have been keen to establish whether these differences are down to 'nature' or 'nurture' (Frosh 1992). A major task of feminist analyses of science has been to expose the biases inherent in such research.

A third aspect of the feminist critique relates to the question *Why so few?* (Rose 1994:12). Rose has documented the difficulty women have not only getting into science but staying in. This observation is borne out by recent figures. Choice of subject for first degrees in the UK continues to vary considerably with gender (see Table 3.1). Female students are more likely to choose education, languages and subjects allied to medicine[13]. Boys, on the other hand, favour architecture, mathematical and physical sciences and engineering and technology. However, a comparison of the years 1988/89 and 1995/96 does indicate an increase of female students in the physical sciences and engineering and technology.

Table 3.1 Female students as a percentage full-time undergraduates

	1988/89	1995/96		1988/89	1995/96
Education	81	76	Humanities	51	53
Allied to medicine	71	74	Agriculture	45	52
Languages	72	71	Medicine and dentistry	45	51
Business and financial	48	49	Physical sciences	29	36
Biological sciences	56	60	Mathematical sciences	25	24
Creative arts	60	57	Architecture	23	23
Combined, general	53	56	Engineering & technology	10	15
Social sciences	50	56			

Source: Figure 3.10, Social Trends, 28, Crown copyright, 1998).

Analysis of the occupational destinations of science, engineering and technology first degree graduates by gender in 1995/1996 indicates that women are at a disadvantage after leaving higher education, being less likely than their male counterparts to pursue a career in this field. Fifty-nine per cent of SET male graduates took up jobs in the area after graduating compared with 39% of female graduates (Social Trends 28, 1998). These data coupled with information on school achievement and patterns of occupational segregation show that although gender differences persist in relation to scientific activity in education and work, the overall picture is one of flux.

[13]This would include speech and language therapy.

In summary, the past thirty years have seen a growing critique of science, where formerly science was seen unquestionably as a force for 'good'. Feminists have been among the critiques of science and have argued that science is integral not only to capitalist domination but also to patriarchy. The sexist bias of science is manifest both in the exclusion of women from practising science and in the content of science itself.

3.4 Science and the practice of health care

In view of critiques of science as a force for the good of humanity and the role it plays in legitimating the participation of some groups over others in its activities, the next section examines the role of science in health care practice, an area of scientific application which is also contested.

It was pointed out in section 3.2 that the public health movement adopted the concerns of the Enlightenment. This included an emphasis on '...progress, rational reform, education, social order, humanitarianism and scientific method' (Lupton 1995:21). Information was gathered through scientific inquiry which, it was believed, would lead to the understanding of natural laws of disease. This section considers broader ways in which science has underpinned Western health care practice. Secondly, it examines the means by which the medical profession has used science as a legitimising force. It then looks at criticisms of the scientific approach to health care including sociological critiques. Finally, it considers recent attempts to go beyond the modernist project of science in searching for 'the truth' about disease, for example, by giving credence to lay accounts of health and illness.

Nettleton (1995) suggests that modern Western medicine, based on what has been termed 'the biomedical model', rests on five assumptions: the mind-body dualism, the mechanical metaphor, the 'technological imperative', a reductionist explanation of disease and the doctrine of specific aetiology. Nettleton underlines a further assumption - that Western medicine is based on 'objective' science which purports to lead in a cumulative fashion towards progressively 'truer' accounts of disease. I would argue that a further significant influence of science on medicine has been that

of research methodology, chiefly experimental and quantitative designs. Each of these aspects of the biomedical model will now be discussed.

The mind-body split derives from the Cartesian view that the mind and body are separate entities, such that the body in isolation becomes 'simply a machine without an organising principle' (Brooke 1993:93). The obstetric profession, for instance, wedded the notion of the mind-body divide to obstetric practice, viewing the pregnant mother as a machine to be fixed, an extreme analogy being that of the broken-down vehicle:

> Since when have repair shops been more important that the production plant? In the early days of motoring, garages were full of broken-down machines, but production has been improved; the weaknesses that predisposed to unreliability were discovered and in due course rectified. Today it is only the inferior makes that require the attention of mechanics. Such models have been evolved that we almost forget the relative reliability of the modern machine if it is properly cared for.....The mother is the factory, and by education and care she can be made more efficient in the art of motherhood. Her mind is of even greater importance than her physical state, for motherhood is of the mind.....(Grantley Dick-Read 1942, quoted in Oakley 1993:67-68).

Brooke (1993) states that the mind-body separation and the levelling of all experience to 'that of the logical' (p.93) had major implications for medicine which from the time of the Renaissance onwards changed medicine from art to science,

> ...the numinous, unknowable mystery of life was discarded in favour of a cold, linear, 'life-as-machine' philosophy, whereby organs and tissues of the body were able to be dissected and to be viewed as entities in themselves' (p.94).

Brooke points out that in present-day medicine the most prestigious medical specialisms are nuclear medicine and molecular biology, those areas which are the most abstract, cold and clinical. The emphasis placed on technology by medicine is also significant, for example, in its application to childbirth. Control over technological interventions in obstetrics enhanced medicine's dominant position in the health division of labour, a point which will be returned to in section 3.5.

A further characteristic of the biomedical model is that of reductionism such that medicine focuses on biological rather than social or psychological factors which impact on health. The 'germ theory' of disease developed in the nineteenth century

provided medicine with a body of knowledge from which to claim scientificity and hence legitimacy. While from the seventeenth century to the late nineteenth century medicine's claim to scientific authority rested on shaky ground, developments in the new science of bacteriology, in which microbes were discovered as a tangible cause of disease, enabled medicine to legitimise itself as scientific. In the USA and rather later in Britain:

> .....the bacteriological laboratory became the new dominant symbol of a new 'scientific' public health, the province of professionals, differentiated from the old, amateur and superstitious public health (Lupton 1995:36).

The germ theory gave rise to the idea that diseases have a causal agent such as micro-organisms, that is, they have a specific aetiology.

Versluysen (1980) has pointed out that medicine, in keeping with the idea of science as a form of certain knowledge and forward progression, has propagated an image of itself as an agent of social progress. The history of health care is primarily that of the ideas and discoveries of medicine's 'great men' who have brought an understanding of knowledge of health to its present sophistication. This view is based on the notion (as discussed in section 3.2 of this chapter) that history is fundamentally progressive since it assumes '...that society is constantly evolving to a higher and ever more rational form of organisation' (p.178).

Medical science draws on the natural sciences as regards both its knowledge base and research methodology. Harrison (1993) has stated that medical education has as its basis the natural sciences; chemistry, biology and physics. Students are '..drilled with factual knowledge and scientific method...' (p.211). The methodology of medicine runs parallel to that of psychology (see section 3.2), striving for the controlled, experimental conditions employed in the natural sciences. An important element in medical research is quantification. Pope and Mays (1993) state that

> Because of their training doctors are often sceptical of anything other than formal clinical trials and research which produces statistical data' (p.315).

This means that qualitative research methodologies such as those used in the social science are rarely used in medical research. Western medicine has favoured quantitative methodology, in particular the randomised controlled trial (RCT). The RCT has been increasingly promoted in the last twenty years and is now the major evaluative tool of medicine (Oakley 1990).[14] The preference of medical clinicians for RCTs is equated with their predilection for science. According to Pope and Mays (1993), qualitative research is not understood by doctors because

> The model of science they know is an experimental one - the randomised controlled trial used to test drugs and surgical procedures (p.315).

I now turn to ways in which a scientific curriculum has been used to legitimate the power and status of the health care professions. By adopting a scientific curriculum based on the natural sciences, the credibility of medicine was assured, even though the benefit of some medical practice may have been questionable. Shortt (1983) shows how biomedical developments paralleled the professionalisation of the medical profession, and in allying themselves with science doctors gained credibility:

> If medicine's science produced few cures, it did suggest satisfying explanations which, in their apparent objectivity, transcended time, place, and class. When, as in the case of medical attitudes towards birth control, these explanations confirmed traditional social values, their popular appeal was assured. It was within the context of this pervasive paradigm of natural knowledge that biomedical innovation contributed to the professionalisation of medicine (p.68).

Elsewhere it has been argued that medicine's case was convincing not on account of the content of medical science itself, but because it was 'an effect of the socio-political struggles which they employed to achieve state recognition (p.32, Nettleton 1995). The profession of obstetrics, for instance, did not become established out of scientific advance. Rather, it achieved its position strategically in relation to midwifery care and through extending its practice from attending problematic births to all births by promulgating the belief that monitoring and surveillance techniques were necessary (Arney 1982).

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[14]The RCT is an experimental test of the effect of a treatment approach. Subjects are randomly allocated to two or more groups; one group receives treatment while the other does not. The results

A number of writers have pointed to the ways in which other health professions have 'scientised' in order to gain status. Physiotherapy, for instance, has emulated the biomedical model to achieve credibility with the medical profession. Roberts (1994) shows how physiotherapy history has been characterised by medical patronage and dominance: 'The founders of what was to become the Chartered Society of Physiotherapy traded professional autonomy for the respectability offered by doctors' (p.362). However, medical dominance did not only relate to institutional power; doctors came to dominate much of the theory and practice of physiotherapy. Physiotherapy education, for instance, is based on the study of the physical body and its mechanical workings in line with the medical conceptualisation of the body as a broken-down machine.

While it has not been suggested that psychology's project of 'scientisation' set out to gain the recognition of doctors, science has clearly played an important role in its claim to recognition. Among its strategies has been the adoption of the scientific method. Sherif (1987) points out that:

> Psychologists, in their strivings to gain status with other scientists, did not pause long on issues raised by the differences between studying a rock, a chemical compound, or an animal, on one hand, and a human individual, on the other (p.43).

Clinical psychology practice, though under increasing scrutiny (see Ussher 1992, for example), still adheres to traditional notions of science. The training of clinical psychologists places great emphasis on the completion of a research project with rigorous research designs (Ussher 1992). Clinical psychology's adherence to science has also meant a concentration within mental health practice on diagnosis, classification and categorisation, with the taxonomic approach becoming dominant:

> .....assuming that if the appropriate symptoms can be identified in correlated clusters, then an objective analysis of the problem can be provided. Psychological intervention can then be applied in the same objective and systematic manner (p.43).

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are subjected to statistical testing to see whether the difference between the groups is down to sampling variability or to actual differences.

Speech and language therapy has similarly looked to science as a means of gaining greater credibility (Eastwood 1988). Given that the profession is of central concern the thesis, this theme will be discussed fully in Chapter 4.

3.5 Critiques of science in health care

What have been the main critiques of the scientific approach to health care, in particular medicine which has been its most ardent proponent? Until recently there has been a widespread belief that medicine has used its considerable power for the social good (Gabe et al 1994). However, the last two decades have seen traditional medicine come increasingly under attack. Critiques have come from a number of sources including sociology, the disability movement (Swain et al 1993), the women's health movement (Roberts 1990, Roberts 1992) and the alternative health movement (Budd and Sharma 1994). A radical critique has also come from the ecofeminist movement which has extended the critique of the growth of science and technology and the consquences of this for the global environment.

Sociological analyses of professional power have led to a view that medicine, rather than being a benevolent social force, is a dominating profession which monopolises 'the provision of health services or responds to the requirements of the economic system' (Gabe et al 1994:ix). Charges such as this question scientific medicine's claims to political and social neutrality and objectivity. Aside from sociological analyses documenting the rise of medical power, the 'scientific truth' of medical practice itself has been called into question. Biomedicine has been critiqued on a number of counts, including the efficacy of medical interventions, the adverse effects of some of its treatments such as pharmaceutical side-effects and its tendency to ignore the social context of illness such as health inequalities related to class, race, gender and age and environmental factors (Nettleton 1995). Medicine has also been criticised for treating the body and mind as separate entities (relating to the mind-body dualism as discussed above) and not 'the whole person'. Also, the truth claims of medicine have been called into question.

The critique of the efficacy of medicine may be illustrated by the case of cervical screening procedures[15]. The reliability of cervical screening to detect cervical cancer in women has been severely criticised, eight incidents of malpractice having been reported in the last five years (Durham 1998). Investigations show this procedure to be unreliable. Technical errors are made in judging whether or not a smear is 'normal' or not, though this appears to be a matter of subjective interpretation, particularly in borderline cases. Much publicity has surrounded that fact that a number of women have died of cervical cancer, after having 'normal' smears. However, the majority of deaths from cervical cancer occur in the 15% of women who do not report for the test.

Cervical screening may have iatrogenic effects including the possibility of cross infection resulting from inadequately sterilised equipment, unnecessary treatment of apparent abnormalities and the anxiety caused by positive tests which do not lead to treatment. Oakley (1998) points out that though one in ten young women have positive smears, the vast majority are not at risk of cancer. Thus the claim of cervical screening to reduce the incidence of cervical cancer is highly questionable. As a doctor reported in The Guardian (Durham 1998):

> Perhaps it is time we admitted a lack of perfection, and that the public is mature enough to accept that.....when we promise otherwise and are found out, there is an outcry.'

While medicine has tended to focus on the body rather than the social context of health and illness, there is much evidence to show that the social context cannot be ignored. The concept of risk (see section 3.3) applies to areas other than health and illness. However, risks created through industrialisation have consequences for health, present day dangers arising from human actions such as pollution, acid rain and nuclear waste. Health promotion initiatives have attempted to draw public attention to lifestyle risks including the relationship between healthy-eating and the prevention of heart disease. However, a problem inherent with this strategy is the

[15]Cervical screening in the UK aims to screen every woman between the ages of 25 and 64 every 3 to 5 years.

difficulty in drawing direct causal links between life-style and health behaviours, a common observation being that people who take strenuous exercise might suddenly die and those who overeat may live to an old age (Davison *et al* 1992). UK health policy in the 1990's has focused on illness prevention, including the White Paper *The Health of the Nation* (Department of Health 1992) which set targets for reducing the incidence of certain illnesses, including stroke and heart disease as well as risk factors including smoking and poor diet. Elsewhere, however, it has been argued that the social basis of health problems need to be taken into account, including environmental hazards (Ashton and Seymour 1988). Indeed, the consultative document published by the government, *Our Healthier Nations: A Contract for Health* (Department of Health 1998) stresses the importance of air quality, housing, water quality and social environment.

A further challenge to biomedical science arises from taking account of lay beliefs of health and well-being (Popay and Williams 1994). As was pointed out in Chapter 2, much informal health care work takes place in the home. The importance of giving credence to lay accounts of health experiences and health behaviours has become increasingly recognised.

The disability movement has also sought to draw attention to the dominance of medical discourse in defining health and illness. Disabled people have voiced concerns that in the past their accounts have been written off as 'subjective'.[16] Woolley (1993), for example, has drawn attention to the dominance of professional discourse around deafness. In her account of becoming deaf she states that:

> All the deafened people I know went home from encounters with professionals to look up words in dictionaries and read up about deafness in medical books. So here we are at this stage in our loss, feeling as though everyone knows more about deafness than we do. Not only that, but everyone who can hear seems to know more about deafness than we do (p.81).

Stainton Rogers (1991) in her research on lay people's explanations of health and illness argues that searching for explanations for health is a modernist view and that

postmodern approaches allow for 'multiple realities' to coexist in accounting for phenomena. She suggests that social scientists should give up

> .....their love-affair with science, stop trying to test hypotheses, and be satisfied with getting some impression of what these different texts are like' (p.37).

This challenges the notion of a dominant account, that is, the biomedical one. Acknowledging the social construction of medical knowledge, that is, the social and political context in which it has developed, allows questioning of

> .....the foundations and credibility of medical science and so elevates the relative status of other forms of knowledge (Nettleton 1995:33).

Thus a postmodern approach questions the idea that a single 'true' account of illness exists, or that biomedical science has led to progressively improved understandings of disease. This gives validity to all accounts whether based on rational science or experience (Nettleton 1995).

The two previous sections have looked at science in health care practice and a number of perspectives which have challenged the dominant biomedical, scientific account. Given these challenges, it is perhaps surprising that science continues to be a prominent factor in the contestation and maintenance of occupational boundaries in the health division of labour. The next section considers the role of science in gendered occupational struggles within this division of labour.

3.6 Science and gendered occupational struggles

Section 3.5 examined in broad terms the influence of science in health care practice. One aspect of this is the use of science to professionalise health care occupations. In this section I draw attention to the gendered character of 'professionalisation through science'. While my thesis is concerned with a hitherto unexplored area, that is, the significance of this process for speech and language therapy, this review of the literature indicates that there is a body of research which has looked at the role of

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[16]See, for example, accounts contained in the volume *Disabling Barriers - Enabling Environments* (Swain et al 1993).

science in the gendering of the health division of labour within and between other health occupations.

This section begins by tracing sociological analyses of the health division of labour. Next, it considers how appeals to science have been made in order to maintain and contest occupational boundaries within the professions of medicine and psychology and between medicine and the female-dominated professions of physiotherapy, radiography, nursing, midwifery and nurse anaesthesia.

Earlier accounts drew attention to the division of labour between medicine and the paramedical occupations, the knowledge base of the latter being heavily influenced by medical control (Freidson 1986). While Freidson acknowledged gender as a factor in the patterning of the health division of labour, he has been criticised, along with others (for example, Rueschemeyer 1986), for inadequately conceptualising gender as a basis for occupational segregation. Later theorists have argued for a more sophisticated analysis utilising the concept of patriarchy, embedded as it is institutionally and within the State. Witz (1992), for example, analyses male and female 'professional projects' undertaken in struggles over gendered divisions of labour in health care.

The 'feminisation' of the medical profession world-wide has been well-documented (Lorber 1984, Reskin and Roos 1990, Notzer and Brown 1995). While historically women were extensively involved in healing practices, the professionalisation of medicine culminating in the mid-nineteenth century, secured professional closure such that women were excluded from medical education (Witz 1992). Struggles in the late nineteenth century and throughout the twentieth century have led to women's increasing entry into medicine. The academic year 1995/1996 was the first in British history in which female students have exceeded the numbers of male students at medical school [17](Annual Abstract of Statistics 1998).

[17]Women were the majority at 15,700 compared to 15,400 men.

Empirical evidence indicates that the constructs of gender and science are inextricably linked within the medical division of labour. Emphasis on science is evident from student selection onwards. Medical schools continue to favour school leavers with high grades in the science (Lorber 1984). Medical school training emphasises detachment from patients and an intellectual, scientific approach to learning. The behaviour of the scientist is encouraged - mechanistic, rationalist and analytical. The stereotypical gendering of science as 'male' and female activity as 'caring' or 'good with people' is evident both at undergraduate level and in practice, with male students expected to be skilled in the scientific approach to medicine and women expected to excel in interpersonal skills including patience and kindness (Lorber 1984). In terms of medical practice, the image of the profession is closely bound up with gender stereotypes, so that in the former Soviet Union, where women predominate, medicine is associated with 'feminine' traits and in the West, where men are the majority, medicine is seen as 'masculine', demanding aggression, objectivity and rationality, again, qualities equated with science. As was noted in 2.6 these stereotypes are to some extent borne out in the medical division of labour with women tending to 'choose' the more people-orientated specialities. Science, therefore, has been depicted as a segregationist strategy embedded within medical education and practice which appeals to gendered metaphors for its justification.

The feminisation of clinical psychology has also been noted. Along with this process, segregation has occurred with science operating as a covert strategy of occupational closure (see section 2.6) Though women are less visible in academia they are now the majority of clinical psychology students (Nicolson 1992). Namenwirth (1988) has drawn attention to the significance of science in maintaining occupational segregation within psychology:

> The scientific enterprise itself became fused in people's minds with the character traits (real or imagined) of the typical Western, white, male. This phenomenon has made it difficult for...hiring and promotion committees to envision women as suitable colleagues (Namenwirth 1988:21, quoted in Ussher, 1992:55).

While Ussher's account of science and gender in psychology acknowledges science's exclusionary function, it also serves to open up a critique of science and pose a counterchallenge to the scientific agenda. This is the primary purpose of Roberts' (1994) analysis of the theoretical basis of physiotherapy. She argues that the occupation's adherence to the biomedical model was a double-edged sword in that by doing so physiotherapy gained the patronage of the more powerful profession of medicine, but at the same time medicine came to dominate both its theory and practice. Adherence to the biomedical model was a trade-off between autonomy and gaining 'the respectability offered by doctors' (p.362). Via a discussion of the social model as defined by the disability movement, Roberts seeks to critique the biomedical model in physiotherapy. Unlike Ussher, however, she does not explore the links between science and gender in the subordination of physiotherapy to medicine, other than to point out that the rise of male-dominated medicine led to the subordination of other health care professions.

A thoroughgoing historical analysis of radiography in the emerging division of health care is provided by Witz (1992), while Cockburn (1985) provides a contemporary picture of the division of labour surrounding medical X-ray (see section 2.7). Of interest are gendered occupational disputes over an area requiring technological as well as patient-centred skills, with the obvious potential to be gendered male-female. Witz points out that the division of labour between technical and caring skills was a significant factor around which professional boundaries in X-ray work were contested and defended. Intra-occupational boundaries within radiography became increasingly articulated within a gendered discourse of male-female relations such that radiographers' work was constructed as a subordinate role requiring the smooth running of X-ray departments, 'like the housewife's tasks, a technician's work is never done' (Radiography 1952, quoted in Witz, p.152).

The demise of male hospital radiographers occurred in parallel to radiographers' increasingly subordinate position in relation to radiologists. The division of labour around X-ray work was increasingly articulated around a gendered discourse which

associated radiologists' work with 'male' skills radiographers' work with 'female' skills. Women's increasing entry into radiography came about largely as a result of their experiences of using X-ray technology as hospital nurses. These women defended the notion that patient-centred skills and technological expertise were of equal importance in radiography. Yet male radiographers denigrated nursing skills, arguing that technical knowledge was all-important. Employment practices secured the feminisation of radiography in a position subordinate to radiology, employing them at the lower salaries of nursing staff. Attempts by male radiographers to stem the tide of women's entry into the occupation were ultimately unsuccessful, despite efforts to define radiography as a technical skill and, unlike physiotherapy as was seen earlier, to resist the incorporation of medical knowledge into the curriculum:

> .....patient care was rapidly becoming indelibly stamped as 'women's work' in radiography and the official incorporation of medical and nursing training into the radiography syllabus was likely to be resisted. Men staunchly defended a definition of the radiographer's role as essentially a technical one, resisting any formal identification of patient-centred or nursing skills with radiography (p.187, Witz 1992).

An extensive sociological literature has analysed the historical significance of gender as a basis of power struggles in the division of labour between medicine and nursing. Here, I focus on appeals to science and masculinity as an occupational strategy in labour divisions between medicine and nursing as a whole, in inter and intraoccupational disputes in obstetric/midwifery care and in the speciality of anaesthesia.

Documenting women's role in healing practices historically, Versluysen (1980) points to the social construction of the history of health care as dominated by a male medical profession whose 'rational' methods were portrayed as vastly superior to 'the supposedly non-rational superstitions of some male quacks and a mass of illiterate 'old wives'' (p.178). Medical history has appealed to stereotypes of women in order to negate their widespread role in healing such as illiterate wives, exceptional old wives, exceptional heroines and ministering angels, these stereotypes contrasting with the supposed rationality of medicine.

Nursing history demonstrates the link between science and gender in healing work: nursing was historically associated with femininity - the womanly qualities of maternality and caring and medicine was associated with masculinity, that is objectivity and rationality. According to Nightingale, a good nurse was also a good woman. Gamarnikow (1978) showed that in the nineteenth century the division of labour between medicine and nursing drew on Victorian ideals of femininity; the passive, middle-class woman was inherently suited to the role she should play in healing - that of a supportive subordinate to doctors. Thus the sexual division of labour in the workplace mirrored the roles of men and women in the family.

Despite nursing reforms throughout the twentieth century including changes brought about in nurse education, there is evidence of continuing troubles over boundaries between medical and nursing knowledge and continuing appeals to 'science' in support of medicine's 'superiority'. Medicine's response to *Project 2000,* for example, was decidedly muted (Davies 1995). When a response was forthcoming from the medical profession, the stereotypical divisions between 'caring' and 'science' were replayed in order to question the need for educational reform in nursing:

> .....basically the heart of the doctor's world is 'science-based'; the essence of nursing is caring. The main aim of a doctor's training is to teach the skills of diagnosis: once you have got that right you have a lot of clues as to how treatment should proceed. The main aim of nursing is to improve the patient's comfort.....(Dean 1992:1161, quoted in Davies 1995:116).

The case of the division of labour around childbirth further underlines the significance of 'science' in the contestation of occupational boundaries in health care, in particular the control of medical interventions. This relates both to the division of labour between midwives and obstetricians (Versluysen 1980, Witz 1992, Oakley 1993) and struggles within the obstetric profession itself (Savage 1986). The technical, interventionist approach to childbirth of medical men dates back historically to the seventeenth century. Struggles over the division of labour between midwives and male doctors gave rise to a boundary constructed around 'assistance and intervention in the process of labour' (Witz 1992:109). Medical practice utilised

the dichotomous constructs of 'normal' and 'abnormal' labour in pregnancy whereby 'normal' labour required assistance and abnormal labour requiring intervention by means of instruments. The use of instruments and the construction of childbirth as a disease allowed medicine to wed obstetric practice to a scientific model of health care. The rise of medical doctors was linked to the development of technical interventions including forceps:

> The rise of obstetrics and its eventual dominance over midwifery was achieved in part by the argument that those who care for childbearing women can only do so properly by viewing the female body as machine to be supervised, controlled and interfered with by technical means. Science or reason, were given (are given) in support of this approach; but were, on closer inspection, a figment of the medical imagination (Oakley 1993:71).

The technologisation of childbirth with a division of labour associated with predominantly female midwives and predominantly male obstetricians still holds true today, with technical interventions much in evidence including foetal monitoring, ultrasound, induction of labour and caesarean section. This is despite considerable misgivings over the dangers of the overuse of technology (Francome *et al* 1993). It is thus of interest that one of the strongest opponents of technological intervention in the field of obstetrics was a female consultant obstetrician. Wendy Savage was suspended from her post in 1985 for alleged incompetence and was later reinstated after a legal battle over claims that she had poorly handled the care of five pregnant women (Savage 1986). The evidence indicated that her suspension resulted from challenging medical orthodoxy surrounding the care of child-bearing women, including the overuse of technology and authoritarian attitudes over the control of childbirth.

Gamarnikow (1988) has shown how technology, skills and scientific knowledge were key issues in the dispute as to whether anaesthesia should develop as a nursing or medical speciality. British nurses demanded the right to practice anaesthesia following the success of nurse-anaesthetists in America. Evidence exists to show that British nurses did practice anaesthesia after World War I. However, the battle which ensued between medicine and nursing over nurse-anaesthesia as merely technical and

medical anaesthesia as scientific secured anaesthesia as a medical speciality. It was argued that the anaesthetist required medical training involving knowledge of physiology and surgery. This involved diagnostic and prescribing skills which would enable the practitioner to monitor the patient's condition before, during and after the operation.

This struggle yet again illustrates the use of 'science' not as a technique proven to benefit patient care, but as a factor in the legitimisation of medical power. Gamarnikow's analysis indicates that the relegation of nurse-anaesthesia to the level of quackery owed less to the lack of evidence of its efficacy and more to a power struggle with medicine. As she states:

> Thus medical opposition to nurse anaesthesia had little to do with science as such, but was concerned primarily to safeguard the status of the medical profession. Whatever doctors did was, by definition, scientific, since medicine was the embodiment of science, whereas nurses were only skilled technicians....(p.23).

According to Gamarnikow, the issue of nurse anaesthetists was primarily political and to do with 'the power to define, evaluate and appropriate knowledge' (p.23). From the viewpoint of medicine the dispute over anaesthesia was not based on an objective scientific analysis of the evidence which demonstrated the safety of nurse-anaesthesia.

This section has considered the significance of science and gender in occupational disputes in the health division of labour. Science has been depicted as a segregationist strategy in the medical division of labour, in which men are seen as suited to the 'scientific' specialities and women to the 'caring', people-orientated specialities. The science-caring dualism has also been highlighted in relation to gendered occupational boundaries in clinical psychology. Historically, the gendering of occupational boundaries in radiography have rested on gender stereotypes of 'appropriate' roles for men and women. Finally, I have noted the significance of science in the maintenance and contestation of interoccupational boundaries between medicine and nursing. The labelling of nursing as unscientific may occur in the face of evidence which shows nursing practice to be effective and therefore scientific.

3.7 Summary

Sections 3.2 and 3.3 of this chapter set out to delineate the principle features of post-Enlightenment science and to examine critiques of science. I drew attention to science's aim of presenting itself as a positive force for humanity which through its methods accumulates 'facts' leading in a forward progression towards ever closer approximations to 'the truth'. Important facets of science are a belief in the rationality of the human subject, detachment from the object under study and knowledge of the whole through understanding the parts. The melding of science with mathematics was deemed to further assist in overcoming subjectivity. From the 1960s onwards there have been mounting concerns from political movements, academics and lay people over the ill-effects of science such that in a 'risk society' it is becoming increasingly difficult to assess the risks imposed by scientific and technological developments. Thus although science remains a powerful force, its aura as the key to human progress is now highly contentious.

Sections 3.4, 3.5 and 3.6 considered the influence of science on health care, critiques of science in health care and the role of science in marking occupational boundaries within and between the health occupations. Parallel with the growth in science has been the professionalisation of health care. Medicine took on the mantle of science in gaining respectability; the biomedical approach to health thus looked to science in framing its approach. The critique of biomedicine has run alongside concerns over the effects of science, including worries over the lack of evidence as to its effectiveness, iatrogenic damage caused by medical procedures and the nature of medical science's dominance over accounts of health care (primarily defined as 'disease' rather than 'health'). Postmodern approaches challenge the over-arching theory of medicine, privileging other accounts of health and illness, including those of lay people.

Feminists have called into question the benefits of science in health care and the part it has played in social control. An important issue which questions the supposed

value-neutrality of medical science is that of the use of science in the professionalisation of medical practice. For medicine, science has been a successful professionalisation strategy, but for the female occupations it has been less so. Thus science appears to shift from gender to occupational power and back again; from justifying the sexual division of labour the legitimising occupational status.

These processes have not been examined in relation to speech and language therapy. I begin this task in the next chapter.

Chapter 4

The role of science in speech and language therapy

4.1 Introduction

While Chapters 1,2 and 3 provided the background to the study, this chapter begins the analytical part of the thesis. I examine documentary and research evidence to highlight the influence of science on speech and language therapy education, practice and research.

Chapter 3 discussed the significance of 'scientisation' in the context of status claims made by the emergent health professions, in particular, medicine. The gender dimension of this professionalisation strategy was also highlighted. Previous research has acknowledged the tendency within speech and language therapy to adopt scientific methodologies in order to achieve greater recognition (Eastwood 1988).

This thesis is a first attempt at a broader analysis of speech and language therapy education, research and practice in terms of their scientific content. In the first sections of this chapter, I show that education, diagnostic categories and research are clearly located within the scientific, medical model. A quantitative analysis of the numbers of women and men in the profession in the last section indicates that in spite of the overwhelmingly scientific nature of speech and language therapy, the vast majority of its practitioners are women. Thus the thesis points to a contradiction - science is normally practised by men, yet speech and language therapy, which identifies closely with science, is dominated by women. This chapter looks at the historical roots of the profession and examines the discourse used in undergraduate degree titles. The language employed in professional practice is then discussed by reference to professional literature. The application of the scientific method in relation to research is examined with reference to a journal volume of the

International Journal of Disorders of Communication (IJDC). Finally, I consider the gender division of labour in speech and language therapy.

4.2 Science in speech and language therapy: professional education

Chapter 3 analysed the influence of Enlightenment ideas about science on health care practice. 'Scientific' healing work was legitimate, according to biomedicine, by being based on an understanding of laws giving rise to disease, a belief in the 'truth' of such discovery and unquestioning faith in the potential of this knowledge to contribute to human progress. Biomedicine allied itself with the modernist philosophy of science which conceptualised the body as separate from the mind, viewing the diseased body as a machine to be 'fixed' through technical innovation. Furthermore, biomedicine was predicated on a reductionist view of health, seeking to explain disease by analysing the component parts of the body in isolation from socio-cultural factors. The methods of science were applied to biomedical research, principally those enshrined in experimental methodology and mathematical measurement.

Chapter 1 pointed to the profession's early attempts to ally itself with science and dissociate from its origins in the field of speech and drama. Quirk (1972), for instance, states that nineteenth century physicians interested in speech, including Hughlings Jackson who published on aphasia, looked to voice teachers for practical experience. These teachers in turn looked to medicine, wanting to identify with 'scientific' explanations of human communication. According to Quirk, the occupation's roots in voice, singing and elocution meant that it had difficulty shaking off these non-scientific associations with elocution:

> Many of these, realising their lack of scientific background knowledge, began to work closely with doctors to build up a body of knowledge of speech disorders and to equip themselves to identify and treat a variety of conditions. This early association with training for the stage has, however, left speech therapy with the unfortunate legacy of being partially identified with elocution in the mind of the lay public (p.5).

Since its early years speech and language therapy has undergone increasing professionalisation. Where formerly educational establishments were independent or

located within colleges of technology or speech and drama, these have gradually become part of the mainstream university sector. Concomitantly, the academic component of the course has increased and in 1985 the occupation became the first all-graduate female-dominated health profession. The 1980s and 1990s has seen continuing credentialisation including an increase in the number of Master's degree courses which offer both initial professional education and a practice-based higher professional qualification. Greater numbers of therapists are now studying at PhD level. Other professionalisation strategies include the introduction of non-statutory registration and service accreditation procedures and the publication of standards of care.

Along with increasing academic standards and following on from the profession's early attempts to dissociate itself from its links with elocution, there have been continued moves to 'scientise' the knowledge base. Eastwood (1988) drew attention to the employment of the scientific method in researching human communication, particularly via the use of experimental design:

> Speech and language pathologists have long been encouraged by their training and by the expectations of the scientific community to apply the principles of the scientific methodologies of the so-called hard sciences such as physics and chemistry to their research into communication disorders (p.172).

The 'scientisation' of the knowledge base is evident from undergraduate course titles. Thirteen educational establishments award Bachelor of Science or Bachelor of Medical Science degrees compared with only two awarding the Bachelor of Arts title (Table 4.1). Seven of the fifteen courses include the word 'therapy' in their titles, whereas eleven include medical or scientific terminology; 'pathology', 'science(s)' or 'clinical'.

Table 4.1 Qualifying courses in speech and language therapy

BMedSci (speech)	University of Sheffield
BSc Clinical communication sciences	Central School of Speech and Drama
BSc Clinical language sciences	Leeds Metropolitan University
BSc Speech Sciences	University College London
BSc Clinical communication studies	City University
BSc Speech and language pathology	University of Strathclyde
BSc Speech pathology and therapy	De Montfort University
BSc Speech pathology and therapy	Manchester Metropolitan University
BSc Speech pathology and therapy	Queen Margaret College
BSc Speech pathology and therapy	University of Manchester
BSc Speech and language therapy	Cardiff Institute of Higher Education
BSc Speech and language therapy	University of Ulster at Jordanstown
BSc Speech and language therapy	University of Central England
BSc Speech	University of Newcastle-upon-Tyne
BA Linguistics and language pathology	University of Reading
BA Human communication studies	College of St Mark and St John

An examination of core subjects on the speech and language therapy curriculum as presented in careers information published by the professional body (RCSLT 1994), reveals that the main focus of the curriculum is on 'scientific' conceptualisations of human communication (see Table 4.2). This includes the study of the structure and function of the speech organs (anatomy and physiology), how speech is produced in the vocal tract (phonetics) and the causation and treatment of language problems (language pathology and therapeutics). The influence of biomedical discourse is also evident in these subject headings. 'Pathology', for instance, is a medical term denoting disease manifestation in organs and tissues; in juxtaposing 'language' and 'pathology' communication disability becomes medicalised. Biomedical science is invoked in descriptions of the subject areas in the leaflet, including the diagnosis-treatment paradigm characteristic of medicine which embodies an implicit assumption that accurate definition of a problem leads logically to a cure. Language pathology, for instance, is described as 'the description, assessment, diagnosis and treatment of disorders of communication'. Of the ten subjects listed under 'other',

seven pertain to the scientific study of human communication. Only sociology and education lie outside this framework.

Table 4.2 Core and other subjects on the undergraduate curriculum

Core subjects	*Other subjects*
Language pathology and therapeutics	Acoustics
Phonetics and linguistics	Audiology
Anatomy and physiology	Ear, nose and throat
Psychology	Education
	Neurology
	Orthodontics
	Plastic surgery
	Psychiatry
	Research methodology & statistics
	Sociology

Source: Speech and Language Therapy as a Career (RCSLT 1994)

4.3 Science in speech and language therapy: professional practice

Though the profession is becoming increasingly critical of 'the medical model' and appears to be distancing itself from this approach, a trend which will be examined further in section 4.5, recent biomedical discourse continues to dominate the main professional publications. Analysis of key documents provides evidence of dominance of scientific discourse. This can be seen clearly in the standards of care for speech and language therapists as described in *Communicating Quality* (RCSLT 1996).

Communicating Quality lists the client groups and presenting disorders for which speech and language therapy provision is made. Tables 4.3 and 4.4 show that the classification of speech and language problems as indicated by the professional discourse of speech and language therapy is largely underpinned by the medical paradigm of causation and symptomology. This underlines the approach employed in undergraduate education which views communication impairments as 'pathologies'; disorders to be diagnosed and treated as medical conditions.

Table 4.3 Client groups as presented in 'Communicating Quality'

Acquired Neurological Disorders
- Cerebro-Vascular Accident
- Dementia
- Neurosurgery
- Progressive Neurological Disorders
- Traumatic Brain Injury

Augmentative and alternative communication
Autistic continuum
Cerebral palsy
Cleft lip/palate and velopharyngeal anomalies
Counselling
Deafness/hearing impairment
Elderly population
ENT services
- Head and neck surgery
- Laryngectomy
- Voice

HIV disease
Learning disabilities
Learning disabilities and challenging behaviour
Mental health
- Adults
- Children

Speech and language therapy in a multi-racial, multi-cultural society

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Table 4.3 shows that the majority of client groups is defined by medical diagnoses including neurological disorders, cerebral palsy, deafness, cleft palate and ear, nose and throat problems. These contrast with other vague, non-specific categories reflecting social categories such as the elderly population or treatment approaches including counselling and speech and language therapy in a multi-racial, multi-cultural society. Presenting disorders (see Table 4.4) cohere more easily, relating specifically to symptomatologies of communication impairments. Medical terminology is invoked in the labelling of the first five categories as 'acquired' or 'developmental'.

Table 4.4 Presenting disorders as presented in 'Communicating Quality'

Acquired childhood aphasia
Acquired dysarthria/articulation problems
Acquired language disorder/adult aphasia
Developmental dysarthria
Developmental speech and language disorders
Dysfluency
Dysphonia
Eating and drinking difficulties in children
Written language disorders

These classifications are not problematised or discussed in *Communicating Quality* whose primary aim is to provide guidelines for good practice. The uncritical nature with which client groups and presenting disorders are described perhaps also reflects the fact that *Communicating Quality* is primarily a policy document. However, this analysis serves to illustrate the way in which the profession portrays its work. In keeping with undergraduate education, clinical work in speech and language therapy is generally conceptualised and classified along scientific, biomedical lines. The emphasis on taxonomy is characteristic of other health professions. In clinical psychology, for instance, there is a prevalent belief that if a diagnosis can be made on the basis of symptom clusters, an objective analysis and treatment plan can be made (Ussher 1992). In common with speech and language therapy, clinical psychology is attempting to dissociate itself with the medical model but in actuality it is, according to Ussher, 'still wedded to categorisation and cure' (p.43).

4.4 Science in speech and language therapy: professional research

The final part of this section looks at the nature of professional discourse employed in the International Journal of Disorders of Language and Communication (IJDLC), the journal published by the RCSLT and received by all its members. This journal has been selected for analysis because it is automatically received by all RCSLT members and as a consequence is more likely to reflect clinical practice as a whole. Also, the *IJDLC* represents the academic face of the profession. Firstly, the overall content of the journal is examined by analysing the titles of all papers published in

the 1995-1996 volume. Secondly, a number of articles are analysed in more depth for content, methodology and practical application.

Table 4.5 gives a breakdown of the content of EJDC papers from 1995-1996. The largest number of papers pertains to clinical issues - 42 out of a total of 62 papers. A sizeable portion of the volume is devoted to technological research - 17 papers. However, only 3 papers are concerned with professional issues, two of these addressing the education of speech and language therapists.

Table 4.5 Content of EJDC papers 1995-1996

Content	Number of papers
Problem-related	
Acquired language disorders	12
Deafness/cochlear implantation	3
Dementia	3
Voice	3
Schizophrenia/mental illness	3
Stammering	3
AAC	2
Acquired dysarthria	2
Semantic/pragmatic disorder	2
Autism	1
Cleft palate	1
Developmental dyspraxia	1
Acquired dyslexia	1
Down's Syndrome	1
Language impairment	1
Learning disability	1
Non-speaking children with cerebral palsy	1
Counselling	1
Total	*42*
Research into technology	
Electropalatography	12
Laryngography	5
Total	*17*
Professional issues	
Content analysis of journal 'Speech'	1
Clinical skills of SLT students	1
South African SLT training	1
Total	*3*

In terms of the total numbers of papers on specific topics, almost half (29 out of 62) are devoted to three topics: acquired language disorders (12 papers), electropalatography (12 papers) and laryngography (5 papers). A number of observations can be made from this analysis. Firstly, technological research is given relatively high priority (in spite of the fact that such technology is used in the main in specialist clinical centres rather than in routine clinical practice). Secondly, acquired language disorders receive a considerable degree of attention even though dysphasia is one disorder among many which therapists treat. I will now discuss these points in more detail.

In line with biomedical science, technological advances are given considerable emphasis, Volume 30, No.3 being entirely devoted to electropalatography and electrolaryngography. The editorial note to this volume invokes the discourse of science, that of experimental design, laboratory findings, quantitative measurement and technological developments. 'Quantitative data' are juxtaposed with clinicians' 'perceptual evaluation', perhaps suggesting that such data provide objective measurements to back up the subjective evidence of the clinician:

> ELG and EPG are two striking examples of 'technology transfer' - from the University Experimental Phonetics Laboratory to the Speech and Language Therapy Clinic where, for some years, they have been contributing not only to clinical measurement (providing quantitative data to complement clinicians' own perceptual evaluation) but also to provision of interactive visual feedback techniques to enhance therapy in speech perception and production (Abberton 1995:iii).

Also of note is the journal's emphasis on acquired language disorders, this representing only one of the many areas of speech and language therapists' work. This corresponds with the observation of Enderby and Emerson (1995) that more studies have looked at the efficacy of aphasia therapy than in any other field. They suggest this relates to the closer allegiance of acquired disorders with medicine and surgery and the fact that these areas were exposed early on to objective assessment in medical research programmes. From this analysis it appears that 'progress' in speech and language therapy research has not necessarily been driven by clinical need but rather by biomedical interests, expressed in biomedical, scientific language. Areas

less closely associated with medicine such as learning difficulties and developmental problems have received far less attention, even though they constitute a large proportion of clinical caseloads (Enderby and Emerson 1995). Also, they use up most of the NHS resources allocated to speech and language therapy. The findings of this analysis corroborate Enderby and Emerson's observation that speech and language therapy research shows 'a marked disparity in volume across specialist areas' (p.167).

Closer inspection of Volume 31, No. 4 1996 reveals the pervasive influence of scientific methodology on research in the field. The following analysis indicates that the articles contained in this journal emphasise the scientific description of human communication disorders rather than focusing on therapy to remediate these impairments. Experimental methodology is the usual method of research. The titles of the papers in this volume are listed below.

Table 4.6 EJDC articles, Volume 31, Number 4, 1996

Title of article	Author(s)
Characteristics of cleft palate speech.	*A. Harding and P. Grunwell*
Speech and language and the cerebellum.	*N. Gordon*
The persisting communication difficulties of 'remediated' language-impaired children.	*B.S. Joffe, C. Penn, J. Doyle*
Language and pragmatic functions in school-age children on the autism spectrum.	*C. Ramberg, S. Ehlers, A. Nyden, M. Johansson and C. Gillberg*
Articulation in Down's syndrome adolescents and adults.	*J. Van Borsel*
A further application of the Fishbein and Ajzen model to therapy for adult stammerers.	*T. Stewart*
Training to meet the needs of the communicatively impaired population of South Africa: a project of the University of Witwatersrand.	*M. A Bortz, C.A. Jardine, M. Tshule*

Of the seven papers, over half (4) are concerned with describing the speech characteristics of certain diagnostic groups: Harding and Grunwell's paper focuses on

the description of cleft palate speech, while Gordon is interested speech and language problems associated with cerebellar lesions. Ramberg *et al* discuss the language of autistic children and Van Borsel's paper examines the articulatory characteristics of speech in Down's syndrome. An analysis of the first of these papers serves to illustrate the scientific bias of the journal.

Harding and Grunwell's paper on cleft palate speech focuses on speech as a discrete entity, as a mechanism which is internally rather than externally-regulated. Cleft palate speech is described in terms of its scientific characteristics involving physical, physiological, cognitive and linguistic aspects. The person with the cleft is 'invisible' within this account which separates out the speech for analysis. The aims of the paper illustrate its scientific emphasis, purporting to provide:

> ....new perspectives on cleft palate speech development and the phonological consequences of early articulatory constraints. Cleft palate speech is perceived as the result of the synthesis between physical, physiological, cognitive and linguistic development (p.331).

The paper reviews research on cleft palate speech in terms of developmental influences, the characteristics of 'phonologically mature cleft palate speech' (p.340) and structural influences. The depiction of cleft palate speech as a pathological entity is evident in the manner in which developmental influences are described. Early vocalisations, for instance, are related to the anatomy and physiology of the neonate's vocal tract. Limited reference is made in the paper to social or cultural factors except to comment on research which found that 'teacher-like mothers' are more likely to use compensatory strategies than 'non-teacher-like mothers' (p.337). Harding and Grunwell do not, however, provide definitions of what is meant by these categories.

It might be expected that papers addressing the application of theory to practice would be wedded to social approaches and less towards positivist science. Of all the papers, Stewart's article on therapy with adult stammerers has the most relevance to practice. The purpose of the paper is to address the problem of maintaining long-term

fluency. Stewart set up group therapy combining speech techniques to control fluency with attempts to change clients' attitudes towards their speech. The research employed an experimental design measuring 'before' and 'after' speech behaviour and attitudes using rating scales. The scores thus obtained were then subjected to statistical analysis.

While this paper, unlike other articles in the journal, does purport to look at psychological aspects of communication problems as well as the remediation of speech in isolation, the design of the study is clearly based on classic scientific principles. Firstly, the researcher takes the position of 'expert', choosing the research methodology, deciding on the variables to be measured, selecting the therapy approach and the instruments used to measure change. The researcher is thus largely detached from the experiences of the people on whom the research is carried out. Secondly, in line with the biomedical approach, the approach to therapy is principally one of locating the problem within the client. At no point in the article are social factors discussed, such as social attitudes towards stammering. Thirdly, the research employs quantitative measures both in therapy and to evaluate the outcome of the research. The 'subjective' opinions or experiences of the study participants are not included within the analysis. Emphasis is placed on statistically validating the experimental findings, again echoing biomedical concerns to legitimate results through quantification.

4.5 Professional challenges to the scientific approach in research

Section 3.5 examined the mounting critique of scientism in health care practice. While science continues to have significant influence on professional discourse in speech and language therapy, as has been shown here, this has not gone unchallenged. This section will examine the nature of critiques of science as well as identifying the gaps and contradictions in this critique. The two elements of science which have been most thoroughly examined relate firstly to methodological issues in research and secondly to challenges to 'the medical model'.

While debates over 'appropriate' methodologies in the field have been on-going since the eighties, the nineties have seen mounting concern with the medical model. Methodological issues have been argued primarily through the pages of the *IJLCD,* while comment on the latter have been raised in other health care journals, in books and in the RCSLT *Bulletin.*

Debates on methodology have focused on two main areas. The first concerns researchers' traditional preference for quantitative rather than qualitative designs and the second relates to the argument that single-case studies are more appropriate than large-scale studies. Eastwood's seminal paper *Qualitative research: An additional research methodology for speech pathology* (Eastwood 1988) made explicit the link between methodology and 'science', arguing that speech pathology has committed itself to experimental approaches in order to counter claims that it is unscientific:

> As speech pathologists we have often been accused of being unscientific. Reaction against this criticism, and the desire to develop rigorous research procedures, has resulted in the increasing used of experimental research methods (p.171).

Eastwood argued for methodological pluralism, including the use of qualitative designs rather than adherence to a single method of investigation. By failing to do so, the field would be unlikely to develop the 'core paradigms' which are said to characterise a mature science and clinicians' questions would remain unanswered.

The paper critiqued the use of quantitative, experimental method based on the hard sciences on the basis of its assumed claims of objectivity, freedom from researcher bias, its claim to reproduce real life situations in the laboratory, and its assumption that experimental design is inherently more rigorous.

While Eastwood opened up this area of debate, her critique of science is restricted mainly to commenting on methodology. Though she was critical of the claim of experimental methodology to value-neutrality, her aim was not to examine the broader implications of science on speech and language therapy. She did not examine, for instance, the influence of biomedical science on speech and language

therapy, which as was seen in section 4.2 is quite considerable. Neither did Eastwood raise the issue of the epistemological basis of speech and language therapy, for instance, the origins of its taxonomic classification.

Pring (1987) also drew attention to methodology as a major issue for speech and language therapy. Unlike Eastwood, however, he is not explicitly concerned with 'science'. Pring advocates the use of single-case designs rather than randomised controlled trials (RCTs) arguing that the former are more likely to be sensitive to differences amongst therapy approaches and amongst different language problems in aphasia. Pring is sceptical that speech and language therapy will be able to improve its methods but cautions that disagreements over methodology will not help the profession. In contrast to Eastwood, Pring advocates consensus over an 'appropriate' methodology rather than plurality in order to avoid the perception that speech and language therapy is in dispute over this issue:

> The message is not an optimistic one and speech therapists face a severe challenge to improve their methods. This challenge will be the more difficult to meet if it is perceived that there is a dispute as to the appropriate methodology (p.163).

While Pring usefully challenges the idea that RCTs and RCTs alone should be used to 'prove' that speech and language therapy works, he continues to be wedded to the notion that experimental designs are superior to other types of research:

> It is important to note that these studies have used specific forms of treatment which have been experimentally manipulated and applied to patients who shared a common deficit in this area (p.164).

He suggests firstly that therapists should evaluate therapy experimentally and secondly that they continue the search for the 'right' methodology. This essentially positivist line involves control of researcher bias and the manipulation of variables. Furthermore, there is a belief in the superiority of the experiment, an assumption which is not questioned in Pring's paper. Pring seeks a method which is 'scientific' in the classical sense. However, he does not question fundamentally the meaning of science in speech and language therapy; the superiority of positivist science is assumed in his account.

Bench (1991), in a reply to Eastwood (1988), is similarly wedded to the notion that speech and language therapy should aim towards defining itself along traditional, scientific lines. In common with Pring he is sceptical that it can do so. He eschews Eastwood's idea that adopting qualitative methodology will lead to the attainment of 'core paradigms' or conceptual models, arguing that developing..... 'a range of interesting and fruitful ideas and hypotheses for the several different facets of speech pathology (p.235)' would be more effective than being concerned with methodological issues. Bench on the one hand argues for methodological plurality stating that the techniques of 'observation and qualitative description are methods as scientific as experimental techniques' (p.237). Later, however, he says that though clinical and research work in the field use scientific methods they depart from science in other aspects. Bench then returns to the natural sciences as *the* model for speech and language therapy, stating that:

> If we can show that the knowledge base of speech and language is essentially of the same kind as the knowledge base of natural science, then there will be reasonable expectation for paradigmatic advances for speech and language pathology (p.239).

In contrast to his earlier position in the paper, Bench equates 'mature science' with hard sciences and mathematics. He states that 'Only variables that can be treated by mathematics are permitted in the physical sciences ' (p.239). This positivist stance is epitomised in his view that 'mature science is made up of facts, concepts and theories that are established firmly and reliably' (p.239). Compared to the certainty of traditional science, Bench is of the opinion that speech and language pathology is an 'epistemological hybrid' (p.240). This is made up of 'elements of consensual knowledge' (p.240) particularly in areas such as physics, physiology and anatomy, voice disorders and 'objective hearing tests' (p.240). On the other hand, Bench sees the humanistic aspects of therapy as negating science:

> Speech and language therapy is an epistemological hybrid. Some of its knowledge base is unambiguous, highly consensual and public, and hence is scientific according to the above definition. Much is not, especially in the clinic where humanitarian considerations play a primary role, to the negation of a fully scientific knowledge (p.240).

Bench, like Pring, does not fundamentally challenge notions of science, taken as given that the hard sciences should be used as a yardstick against which the scientificity of speech and language therapy should be judged. Bench sees speech and language therapy as lying outside science and his tone is generally pessimistic as to the discipline acquiring such status:

> .....it could be wise to start with secular paradigms that deal with the separate facets of speech and language pathology one by one. Such secularity may be all that is attainable by speech and language pathology. If so, the development of lots of little theories and paradigms, whatever the methods, is the way to go.....(p.241).

A number of studies in the mid to late nineties have mounted a challenge to the medical model which has driven much research in the past. Research at City University, influenced by disability politics, has utilised the 'social model' on which to base its research into aphasia. Pound (1996) documents how this work has set out to challenge professional power and give credence to the accounts of people living with aphasia. Furthermore, this research attempts to distance itself from medical emphasis on impairment, treatment and cure, focusing instead on living with a disability. This research uses a qualitative design with a consultative advisory panel of people with dysphasia for 'feed forwards and feedback at every stage' (p.13). The work of Kagan and Gailey (1993) at the North York Aphasia Centre similarly aims to shift the focus away from direct therapy towards working with the partners of people with aphasia. This project also acknowledges the influence of people with aphasia and volunteers taking part in therapy on research ideas at the centre.

Though these studies signal a change at the methodological level, non-experimental research is still a rarity in speech and language therapy, ten years after Eastwood's paper. Enderby and Emerson (1996) note that qualitative studies have made little impact on efficacy research in the field. A second point is that though these studies address aspects of science in terms of critiquing the medical model, they do not directly challenge the epistemological basis of speech and language therapy and the power structures which underpin this knowledge. The study at City University, for instance, confines itself to a critique of medical in terms of the medical model of

disability. It does not consider the broader ramifications of medical power and how this may impinge on the work of speech and language therapists, for example, through its hierarchical position in the NHS.

Enderby (1992) has also sought to apply a broader definition of health to speech and language therapy in her work on outcome measures. In common with the aphasia therapy studies discussed above outcome measures as proposed by Enderby should incorporate patients' and relatives' views in goal-setting and judging the perceived benefits of therapy. Similarly, these measures seek to assess the outcome of therapy in terms of the broader impact of therapy for the client rather than looking to improvements on traditional assessments which focus on phonetic or linguistic factors, for instance. Enderby, in parallel with the aforementioned aphasia studies, strives to move away from a focus on communication problems as impairments needing to be 'fixed'. This could, of course, be seen as a political strategy in an 'evidence-based' climate. If impairments cannot be cured, then possibly speech and language therapy has a positive effect on well-being, quality of life and so on.

This work while laudable in its attempts to develop alternative ways of assessing the effects of speech and language therapy and move towards a social conceptualisation of health, does not fundamentally challenge the underlying scientific basis of the discipline. As was seen in section 4.4, science continues to dominate speech and language therapy discourse. The above examples provide a counterpoint yet fail to engage with a debate examining these tensions. If definitions of health are changing within the profession in line with those promoted by the World Health Organisation (Enderby 1992), why do the majority of papers published in the field continue to reflect a major bias towards positivist, experimental work?

Chapter 3 discussed the political nature of science, for example, its tendency not to deal with problems which are too complex or too metaphysical in nature. Bench, for instance, appears to see the complexity of speech and language therapy as a problem

rather than a challenge, including its interdisciplinarity and the fact that emotions come into the work:

> .....the concepts used in much of speech and language pathology lack the precision and clarity of concepts in the natural sciences, and many are, frankly, 'woolly'. Some have indeterminate boundaries - the boundary between aspects of language theory and language pragmatics, for example. Others are far from completely unambiguous, such as descriptions of the emotions (p.240).

The accounts discussed above challenge certain aspects of science. The work of Enderby, Pound, Eastwood and Kagan and Gailey consider power issues between therapist and client and how this relationship might be balanced more equitably through the use of more sensitive research methodologies and assessment procedures. Pring and Bench, on the other hand, support a scientific model of human communication, a model to which speech and language therapy, in their opinion, should aspire.

4.6 The gender division of labour in speech and language therapy

Section 4.5 examined critiques of traditional science in speech and language therapy, including issues of methodology and conceptualisations of health. Other than to point out that science is a necessary legitimating factor in proving therapy 'works', these critiques fail to engage in a discussion over scientific power and the role science plays in patriarchal domination. If women have been excluded from science and from the production of scientific knowledge, what are the implications for speech and language therapy, a profession which (at least outwardly) aspires to scientificity?

Chapters 2 and 3 examined the gendering of health care work, pointing to women's role in the private sphere as providers of unpaid health care and their subordination into the lower echelons and lower status positions in the public sphere of paid health work. Coupled with this division of labour it was noted that appeals to gendered stereotypes have served to uphold the division of labour, equating 'science' with male work and 'caring' with female work, in spite of the shaky ground on which the term 'science' rests. This section examines gender division of labour within speech and language therapy. The populations examined include students, NHS clinicians

and managers, university staff, researchers and writers and members of RCSLT committees.

Figures indicate that men are still in the minority in terms of numbers of qualifying students. In 1996, 473 students qualified and of these only sixteen (4%) were male (Beer 1997). Comparisons over time are not possible owing to the lack of detailed data for past decades. However, given the small increase in the numbers of male practitioners (as will be seen later), it is likely that there has been a slight concurrent increase in the numbers of male students. This provides a clear indication that speech and language therapy is generally perceived as an 'appropriate' career choice for women but not for men, even though the primary focus of the undergraduate course is on the scientific aspects of communication, an image reinforced by the careers literature (see section 4.2). This issue will be considered in depth in Chapter 6.

Data on speech and language therapy practitioners indicate that women are the overwhelming majority of practising therapists in the NHS. Moreover, this pattern has remained virtually unchanged over the last twenty-five years. The Quirk data, based on figures from the late sixties, noted that women made up more than 99% of all practising speech and language therapists in the UK. At that time only nine men were in practice and a further twenty-six had taken up other professions or gone abroad to work. The proportion of men rose slightly over the next twenty years to 1.89% in 1991 (Manpower Advisory Group 1991). This figure is substantiated by statistics from a study of a cohort of 1983-1989 graduates, 1.9% of whom were male (Bebbington 1995).

Turning to the areas of teaching, research and involvement in policy-making roles in the profession, it is evident that the female-male balance tips more in favour of men. This accords with the pattern of vertical segregation found in other areas of health care in which women are typically found in 'hands-on' roles deemed suitable to the feminine personality. Men, on the other hand, are typically found in the more prestigious roles perceived to be suited to the stereotypically masculine qualities of

objectivity, rationality and detachment. While data are unavailable on the gender composition of the fifteen academic establishments, it is interesting to note that four of the fifteen heads of department are male, that is over a quarter.

In terms of research and academic writing, men's participation increases with the prestige of the various activities. Of particular interest is their involvement in writing articles and books, that is in the area of knowledge production, arguably the most influential areas of speech and language therapy. They make up a sizeable proportion of editorial board members of the professional journal, of authors of published papers and books and of book reviewers. In 1996, seven of the twenty-two members of the *EJDC* editorial board were male including the associate editor. They were first authors of five of the twenty-one papers published in the 1996 volume. Of the books reviews over this period, men were the majority of authors and women were the majority of reviewers. There were equal numbers of men and women named as first authors of books, while more men that women acted as editors (Table 4.7).

Table 4.7 Book authors and reviewers, EJDC 1996

	Book authors	
	Male	*Female*
First editor	5	3
First author	5	5
Total	*10*	*8*

	Book reviewers	
	Male	*Female*
First author	4	13

Thus compared to their numbers as practitioners, men have a significantly higher profile in academic knowledge production, particularly in relation to book writing where their numerical presence overtakes that of women.

As in clinical psychology (see Chapter 2), men are well-represented in proportion to their numbers on professional committees (even though their numbers are still relatively small). An analysis of data provided by the RCSLT Annual Report 1996-1997 (RCSLT 1997) indicates that although women dominate RCSLT committees numerically, men's participation is higher proportionally than their involvement in managerial or clinical work. In 1996 6.9% of all committee members were men. Most pertinent to this thesis, however, is the observation that all but two of the eight men are members of boards associated with technological and scientific/academic issues, that is the Information Management and Technology Board, the Research Committee and the Academic Board. Other than the one male on the Accreditation Working Group they are not represented on committees dealing with practice-related areas such as Professional Standards, the Registration Working Group and Regional Committees.

Table 4.8 RCSLT Committee membership

	Men	Women	Total
Academic Board	2	14	16
International Committee	-	10	10
Advanced Studies Committee	-	7	7
Professional Standards	-	7	7
Accreditation Working Group	1	5	6
Registration Working Group	-	7	7
Executive Committee	-	8	8
Finance Committee	-	7	7
Regional Councillors	-	7	7
Ethics Committee	1	7	8
Information Management and Technology	2	7	9
Research Committee	2	6	8
Publications Committee	-	5	5
Students Committee	-	9	9
Total	*8*	*108*	*116*

Source: Annual Report 1996-1997 (RCSLT 1997)

4.7 Conclusion

This chapter has pointed to the pervasive influence of traditional notions of science on speech and language therapy. The profession has a scientific curriculum, a scientific qualification and its research is based by and large on a traditional biomedical model. Furthermore, speech and language therapy practice is dominated by biomedical discourse.

The analysis carried out in section 4.2 indicated that undergraduate education tends to focus on the scientific aspects of human communication rather than on its humanistic elements. Despite some challenges from within the profession, the bias of published research is towards a positivist, scientific agenda which has limitations with regard to clinical application. While the profession is to some extent advocating methodological plurality and is becoming increasingly critical of the medical model, these developments do not fundamentally challenge science as an issue of power in

the profession. This is despite growing popular scepticism over the idea of science as a source of human progress and increasing awareness of science as an instrument of social control.

There has been no attempt to examine the implications of science as a gender issue in speech and language therapy, even though extensive evidence shows that science has historically been the preserve of men. I have shown here that vertical segregation exists in the profession, in spite of the fact that there are very few men. The few men who are to be found in the profession are overrepresented in the prestigious area of academic knowledge production, but they are virtually absent at the 'grass-roots'.

The field work described in Chapters 5-10 further examines the tension between scientific activity on the one hand and 'caring' work on the other, focusing particularly on the gendered nature of this dualism in which the highly-prized activity of science is generally equated with masculinity and the undervalued work of caring with femininity. A further aspect of this tension is that although speech and language therapy is scientific it is still female. These issues are explored through the accounts of practising speech and language therapists.

Chapter 5

Methodology and the research process

5.1 Introduction

In chapters 2-4 which reviewed the literature and located speech and language therapy, issues around its marginality have become clearer. Speech and language therapy is a science-based occupation, but even when science is a marker of occupational status, the profession has not acquired recognition.

The central research questions I address in the fieldwork are as follows: to what extent does the fact that the vast majority of speech and language therapists are women explain the marginality of the profession? Furthermore, given the scientific content of speech and language therapy, why does the occupation not have higher status given that science is normally associated with high status occupations?

The empirical work described in Chapters 5-10 is the first attempt to explore the significance of gender in the marginality of speech and language therapy by placing the therapists' accounts at the centre of the analysis. As Patricia Hill Collins (1990), quoted in Marshall (1994:111) states:

> Offering subordinate groups new knowledge about their own experiences can be empowering. But revealing new ways of knowing that allow subordinate groups to define their own reality has far greater implications (p.222).

This chapter describes the methodology and the research process, while chapters 6-10 present the research findings. In section 5.2 of this chapter I discuss my rationale for adopting qualitative interviewing as a research method. I then discuss my reasons for using a feminist approach. Section 5.3 describes the fieldwork including topics covered in the interviews, the sampling procedure and the approach to data analysis. The final section contains reflexive observations on the fieldwork.

5.2 Qualitative interviewing and feminist research

In this section I discuss the rationale for using qualitative rather than quantitative research in studying speech and language therapists experiences. The decision to carry out interviews is discussed before moving on to address the implications for adopting a feminist perspective for the research.

Quantitative research is equated with studies which attempt to analyse data numerically. In scientific research this typically involves setting up an experiment and numerically coding the results. These data are then subjected to statistical testing to support or refute one or more hypotheses. In the social sciences, quantitative data are chiefly collected via postal or face-to-face surveys. In structured interviews or questionnaires the respondent is asked a series of predetermined questions to which there is a set number of possible responses. By contrast, qualitative research is generally characterised as highly flexible and unstructured. A method which typifies this form of research in the social sciences is the in-depth, unstructured interview. This may simply involve a prompt question but no other set agenda. Robson (1993) illustrates the differences between quantitative and qualitative research by citing, as an example of the former, the self-completion questionnaire based largely on closed questions. Qualitative research is exemplified in the 'free-range' interview which has a fluid agenda and open-ended questions.

Chapter 4 pointed to the on-going debate in speech and language therapy over the quantitative-qualitative divide, an issue which has concerned health researchers, sociologists and feminists alike.[18] Quantitative survey research which came to dominate sociology in the middle decades of the century and continues to be highly influential has come under increasing scrutiny. Feminists, for instance, argued that quantitative research produced distorted information in that it approached research by asking questions precoded and precategorised according to the researcher's bias. This, they posited, led to an inaccurate representation of people's lives (Maynard

[18]In relation to health, see Pope and Mays (1993), Kellehear (1993) and Ussher (1992). Maynard (1994) discusses recent thoughts on the qualitative-quantitative in feminism, while Fontana and Frey (1994) document the history of this debate within sociology generally.

1994). In order to counterpose what was seen as a method alienating to women and which produced gender-biased research, feminist scholars sought an approach which, as Maynard puts it, 'maximised the ability to explore experience rather than impose externally defined structures on women's lives' (p.12). However, this replicated a situation of methodological orthodoxy in which quantitative methods no longer dominated; qualitative research became the principal means through which feminists explored women's lives, even though some feminists continued to use quantitative techniques throughout this period, for example, Hakim (1979), Dex (1988).

An important argument as regards the quantitative-qualitative debate in the social sciences related to the assumption that quantitative research is positivist in stance, i.e. that it perceives itself to be based on a value-free paradigm, purports to be objective in its approach and involves the testing of hypotheses through logical deduction. Qualitative research, on the other hand, is stereotypically characterised by an inductive approach in which the researcher enters the field apparently free of *a priori* theory. However, commentators from within and without feminism have critiqued the assumption that only quantitative research is deductive.

Bryman (1984) argues that there is no clear-cut distinction between epistemological positions (for example phenomenological and positivist) with their associated techniques, for example, participant observation and social survey. In a now classic paper entitled *Defending the Indefensible? Quantitative Methods and Feminist Research,* Kelly, Regan and Burton (1992) challenged the idea of the in-depth interview as the definitive approach to feminist research describing their employment of self-report questionnaires in examining the prevalence of sexual abuse. Kelly *et al* comment on the difference in the range and depth of what young people in the research chose to tell. The self-report questionnaire provided a context through which participants could choose whether or not to disclose or withhold information, an option which would not have been possible in a face-to-face interview, particularly in view of the sensitivity of the topic.

Sociologists, feminists and latterly health researchers are advocating methodological plurality. Maynard (1994), for instance, points out that there is now insufficient evidence for feminist research to adhere to the 'old orthodoxy' of rejecting quantification (p.14). Similarly, in relation to health research Kellehear (1993) argues that:

> Methodological choices should complement the research questions asked, as many a textbook will argue, but furthermore, the methods should also be sensitive to the needs and features of the respondents or social processes being studied (p.126).

Given the current position within feminism and sociology more generally that the method should be appropriate for the research questions, why opt for qualitative research in researching the careers of speech and language therapists? Chapters 1 and 2 discussed previous research in this area which has by and large utilised survey formats. Even where this research involved interviewing, subsequent reports focused on a quantitative analysis of the data. Ware's (1988) research, for example, involved interviewing fourteen District Speech and Language Therapists. These interviews were not taped, transcribed or analysed as part of the project but were used as a means to access answers to specific questions such as the numbers of people who had left their posts, their date of leaving, clinical speciality, official reason for leaving, whether full or part-time and so on. This information was used as the basis for the questionnaire Ware subsequently sent to the 'leavers'. Furthermore, studies on speech and language therapists' careers have taken a largely positivist line in research, being concerned with seeking 'factual' information on issues such as staffing levels or elucidating reasons for leaving the profession. None of these studies sets out or makes explicit a conceptual framework which might provide an in-depth exploration of the problem of speech and language therapists' employment.

A qualitative design allows for research which explores speech and language therapists' experiences in an open-ended way. It also permits an analysis based on a theoretical position which has been tentatively formulated and explicated by the researcher. Such an approach moves away from the traditional 'linear' method of research involving induction or deduction. Previous accounts of the occupation of

speech and language therapy have focused on the profession in isolation from the social and political context in which health care is provided. Qualitative research affords the possibility to explore theoretical explanations for the marginalisation of the work, including concerns arising from feminist research into women's roles as health care providers (see Chapter 2). In using an open-ended format respondents could agree or disagree with these formulations on the basis of their own experience or propose alternative conceptualisations for the issues under discussion.

Furthermore, by asking speech and language therapists about their experiences using an unstructured format additional questions could be discussed and further themes identified. Thus in view of the tentative nature of the research which was a foray into the unexplored area of speech and language therapists' experiences, a qualitative approach was imperative so that assumptions and theories could be developed or challenged. A further advantage of a qualitative approach was that it enabled a consideration to be made of the particularity of speech and language therapists' work, another aspect previous research overlooked. Exploration of the respondents' experiences, it was hoped, would distinguish speech and language therapy from other forms of work in contrast to other studies which have not taken into account the specialised nature of this occupation.

The method chosen for the study was face-to-face interviewing rather than postal questionnaires. The latter would have limited the number of questions asked and would not have allowed for the exploration and development of ideas. Furthermore, such an approach would have meant the need to standardise questions. Open-ended interviewing gave the possibility of orienting the content to the specific situation of each interviewee, as will be seen in section 5.3. The advantages of face-to-face interviews are highlighted in a study undertaken by Bart and O'Brien (1984) on the subject of rape. They interviewed women using a schedule incorporating semi-structured and unstructured elements. By careful listening new questions were introduced as the interviews proceeded. Bart and O'Brien argue that in this way the interviews became focused on the interviewees rather than on the interviewer.

Furthermore, interviewing would allow greater reciprocity between the researcher and 'the researched'. Lather (1986) suggests this is an important feature of 'praxis-oriented' research and that interviewing should be conducted in an 'interactive, dialogic manner that requires self-disclosure on the part of the researcher' (p.266).

Feminists have long debated whether feminist research is a form of inquiry with characteristics which distinguish it from other forms of research. The case for a distinctively feminist mode of inquiry is hard to ignore, given the growth of writing in this area over the last twenty years (Roberts 1981, Stanley and Wise 1993, Bowles and Duelli Klein 1983, Cook and Fonow 1986, Harding 1987, Stanley 1990, Maynard and Purvis 1994). I will now enter into the debate as to whether there is a distinctive feminist approach, arguing that there are indeed aspects of a feminist perspective which distinguish it from other types of research and that these features render a feminist stance essential for the study described here. Maynard (1994) sums up the terms of the debate stating that there is no clear consensual definition of feminist research though there seems to be general agreement that it is distinctive:

> It seems to be widely accepted by feminists themselves that there is a distinctively feminist mode of enquiry, although there is by no means agreement on what this might mean or involve (p.10).

The issues surrounding this debate centre on three areas: method, methodology and epistemology. Much of the earlier argument for a distinctive method in feminism centred on the predilection of feminist researchers for using qualitative face-to-face interviewing, a point raised earlier in this section. Recent challenges to this position and a recognition that quantitative research also has its place have rendered the notion of a distinctively feminist method increasingly untenable.

Maynard suggests that a more convincing case for feminist research derives from its concerns with methodology, two principal issues being the distinct theoretical perspectives feminists have adopted and secondly the attention feminists have paid to critiquing the actual process of research. Regarding the first of these concerns, though feminist research is concerned with women's oppression, it is clear that

different theoretical positions exist which lead to 'different sorts of questions and to the production of different kinds of knowledge and analysis' (p.15). Maynard points out that different conclusions will be reached, for instance, depending on whether the researcher conceptualises gender in terms of divisions and inequality or patriarchal power.

Feminists have posited alternative ways of approaching old and familiar research methods, including the interview. Oakley (1981), as documented in her classic account of interviewing women, departed from conventional practice. In her study of women's transition to motherhood, rather than maintaining a detached, impersonal attitude, Oakley describes how she took on a role which was more like 'a friend rather than purely as a data-gatherer' (p.4), for instance, the interviewees in the study asked many questions Oakley felt unable to avoid.

While many feminists have discussed the need to democratise the research process, more recent work has brought into focus the difficulties of putting such ideas into practice. For instance, while non-hierarchical relationships may be created within the interview setting there is still enormous scope for researcher bias 'after the event'. Holland and Ramazanoglu (1994) speak of the power researchers wield in relation to the interpretation of research findings, while Glucksmann (1994) draws attention to the researcher's power in defining the subject matter of the research and the questions to be asked. Glucksmann also points out that the perspectives of the researched are 'fragments' of the 'total' picture the researcher creates from many different sources of information. Thus the perspectives of the researched may not necessarily coincide with those of the researcher. Indeed, Maynard and Purvis (1994) suggest that 'There is no such thing as 'raw' or authentic experience which is unmediated by interpretation' (p.6).

A final aspect of feminist research relates to epistemological debates over who creates knowledge and the nature of such knowledge. Chapter 3, for example, highlighted feminist critiques of science which pointed to the exclusion of women

from the creation of scientific knowledge to the extent that science may be said to reflect masculine values. Feminists have argued for a number of 'feminist epistemologies' including empiricism, standpoint theory and postmodern feminism. A central issue in developing feminist epistemology relates to whose standpoint is being taken in research and whether different standpoints are represented, including those of Black, feminist, disabled, working class and lesbian women. Although there is no clear agreement on the question of epistemology, a defining feature of feminist research is the contentiousness over the issue as to whose viewpoint is represented in any one research account.

Given the above characteristics which mark out the activity of feminist inquiry as distinct from other forms of research, why apply feminist research to the study of speech and language therapists? Such a viewpoint coincided with the notion that the problem of speech and language therapists' work could be influenced by the fact that the overwhelming majority of practising therapists are women. It was felt that the issue of the low profile of this work could be explored in relation to the undervaluing of 'women's work' in general, in particular by drawing on feminist theory which acknowledged and sought to account for women's oppression including in their roles as workers. The research aimed to go beyond individualistic explanations which located career decisions as based on individual agency, including the theory, for instance, that career choice stems primarily from the personality traits of the individual (see for example Holland 1966). A feminist approach allows for a sociological exploration of speech and language therapists' careers seeking to examine the correspondences (and differences) between therapists' individual experiences and sociological explanations for women's oppression. However, this does not preclude the idea that women should be the only subjects of study. Thus the present research did not set out to exclude men from the study as will be seen later. Indeed, other researchers (see for example Marshall 1994) have included men as subjects when researching women's issues.

Though the debate over the distinctive character of feminist research continues to be hotly debated, feminist notions of research as a reflexive process were felt to be highly relevant to the present research. Such an approach contrasts sharply with that normally applied in speech and language therapy research in which the person of the researcher remains hidden and the effects of the research on the researcher and 'researched' do not enter the account (see section 4.2). Earlier considerations of this thesis regarding the political nature of knowledge production, especially in relation to science, made it imperative for the researcher not to separate the research process from the products of the research. Lovering (1995) documents a comparable process in her research on adolescents' talk about menstruation, describing a shift in her epistemological position from a traditional psychological perspective which seeks to posit rational, objective explanations to a poststructuralist discourse analytic approach which addresses the political context of knowledge production. This she does through a reflexive account of the incompatibility of her political aims as a woman and researcher with traditional psychology:

> As a feminist, I found this standpoint increasingly incompatible with my commitment to the improvement of women's position in science and society, and with my experience as a menstruating woman and female researcher. The separation of the means of doing research from its ends, the removal of the researcher from the research process, and the assumption that 'facts' can be collected about the social world can place the researcher in the position of simply reflecting and perpetuating 'unequal power relations which already exist in the society' (May 1993:41) (Lovering 1995, p.11).

The significance and power of the researcher at all stages of the research was highlighted above and in order to counter the notion of research as a politically and socially neutral activity it becomes essential to incorporate reflexivity into the research process. Chapter 1 explained how this study arose from personal concerns over the marginality of speech and language therapists' work. Using 'the personal' as a starting point is a strategy common to much feminist research.[19] Reflexivity includes a commitment on the part of the researcher to critically analyse her position within the research including her theoretical assumptions and beliefs, her relationship with the subjects of the research and a consideration of the consequences of the research. As will be discussed later, certain ambiguities arose for the researcher in

[19]See for example Ladner (1987), Greed (1990), Marshall (1994), Morris (1989).

terms of possessing the identity of a speech and language therapist but who was also becoming a researcher 'known' within the profession for her work on therapists' careers.

In addition reflexivity regarding the outcome of research is important for this project. For established researchers residing within the academy there may be a clear-cut agenda to advance the causes of feminism legitimated through funding and the establishment of research teams. Kelly *et al* (1994), for instance, state that the desire and goal in doing research for their team was 'to create useful knowledge, knowledge which can be used by ourselves and others 'to make a difference' (p.28).

5.3 The interviews

Content

The main aim of the interviews was to explore with my respondents the reasons for the relatively low profile of speech and language therapy in the health care system and whether they thought that the marginalisation of the profession was associated with the fact that the large majority of practitioners are women. I wondered whether the low profile of the profession was symptomatic of the undervaluing of women's work in general. Given the importance of science as a status issue for the health care professions, I was also concerned to examine the part played by science in my interviewees' education and clinical practice, for example, the extent to which speech and language therapy education was perceived to focus on the scientific aspects of human communication and how therapists dealt with this in their transition to becoming practitioners. In particular, I wished to examine the gender dimension of science and the tensions this must inevitably raise for a female profession seeking recognition through scientisation, for if science is gendered 'male'then there are obvious tensions.

In order to examine these questions across a range of different viewpoints a basic structure was used to cover the main subject areas. A life-history format was utilised. Firstly, people were asked to describe how and why they chose speech and language

therapy as a career and secondly they were asked to recount their experiences of their professional education. Thirdly, I enquired as to the interviewees' career paths after they had qualified.

As was discussed in section 5.2 the unstructured format of the interviews permitted flexibility to allow for reflection on the specific circumstances of individual participants. Older therapists, for example, were able to provide important insights into historical developments within the profession, while people who worked part-time discussed issues arising from this form of work. As a prompt an interview guide was used (Table 5.1). This ensured that while there was a 'naturalistic' conversation, a number of topics would be covered systematically. However, it is important to say at this point that despite the 'neatness' with which the content of the interviews is here portrayed, it was clear in several of the interviews that my interviewees and I held agendas which did not necessarily correspond. I will return to this issue in section 5.4.

Table 5.1 Interview guide

Choosing speech and language therapy as a career
How did you get into speech and language therapy?
Why were you interested in a 'caring' profession rather than accountancy, medicine or law?

Experience of professional education
How did you find your professional education?
How did it prepare you to do the job?

Career since qualifying
How has your career developed since then?
What has held your career back?
What has facilitated it?
How do you see the future?
Why do you think speech and language therapy has a low profile?
Is there anything else you wish to talk about?

Sampling

Having decided on the format of the interviews in terms of the content to be covered, I set about obtaining a sample of speech and language therapists who would be prepared to talk around this subject. The approach was not to find a sample which would be representative of all speech and language therapists as the intention was not to enable generalisations to be made beyond the sample studied. The main aim of the sampling techniques used was to obtain a variety of views in order to guard against essentialising speech and language therapists' experiences. A version of the technique of purposive sampling was utilised in which the selection of subjects is made according to the interests of the research topic (Robson 1993). The initial six interviewees were selected to satisfy a number of criteria. The first, as already stated, related to selecting as broad a sample as possible in order to avoid generalising about women's experiences. The second criterion was that the research should not overlook men's experiences and thirdly that the sample should reflect major themes relating to women's position in the labour market. The final aspect was that the interviewees should represent speech and language therapists 'down the generations' to give a historical perspective to the account. On the basis of these criteria six therapists were chosen as initial interviewees, as indicated in Table 5.2.

Table 5.2 Initial study participants

A part-time therapist
A newly-qualified therapist
A therapist nearing retirement
A male therapist
A 'high-flier'
A therapist at the 'mid-point' of her career

Three of these interviewees were already known by the researcher and the names and addresses of the remaining three were obtained through colleagues. All six agreed to take part in the study. In order to further achieve the goal of tapping as wide a variety of opinions as possible, the names and contact numbers of the remaining thirty-six

subjects were obtained using a strategy derived from Personal Construct Theory (Kelly 1955). Each of the initial six interviewees was asked to nominate one therapist they regarded as similar to themselves and one regarded as different.

The forty people who eventually took part in the research represented speech and language therapists in varied work situations in terms of speciality, occupational status and work setting. They were also varied in terms of biographical factors such as age, gender and ethnic background. People had a wide spectrum of clinical experience including in the areas of paediatrics, language disorder, hearing impairment, cleft palate, dysphagia, dysphasia, laryngectomy, autism and voice. Therapists at different grades were interviewed including managers, specialist, generalist and newly-qualified therapists. Most people were based in community health establishments or in schools, but a few worked in hospital settings. As regards demographic factors, interviewees were both male and female and their ages ranged from 23 to 62. For reasons of confidentiality details of variations in therapists' ethnic background are not given here (I will return to the issue of confidentiality in section 5.4). Over half the sample qualified in the seventies and eighties, however people graduating in the nineties were also well-represented (see Figure 1).

Table 5.3 Profile of the sample by gender and decade qualified

	Decade qualified				
	1950's	1960's	1970's	1980's	1990's
Female	3	5	10	14	7
Male	-	-	1	-	-
Total	*3*	*5*	*11*	*14*	*7*

The participants were contacted by telephone. I explained that I was undertaking a research project looking into the low profile of speech and language therapy and that I was interested to talk with practising therapists as to whether they also saw this as a problem and how they felt about it. I further explained that the discussion would focus on three main areas: how they chose speech and language therapy as a career,

how they found their professional education and how their career paths had subsequently developed.

Confidentiality was stressed and participants were informed that no proper names would be used in the research. In practice, the issue of confidentiality proved to be of major concern to both the researcher and some of the research participants. It soon became clear that merely omitting names was not sufficient to maintain confidentiality, particularly in view of the small size of the profession and the fact that the majority of therapists are white women.

A date, time and place for the interview was agreed with the interviewees. I was keen to be flexible as regards where and when to carry out the interviews, being prepared to travel to therapists' place of work or homes and to conduct the research in the day time or evening.

Of the forty people contacted, none declined to take part despite my initial trepidations that finding sufficient numbers of people willing to participate would be problematic. I suggest that people's enthusiasm was in part due to the fact that I was flexible about the time and place of the interviews. However, I believe a more important factor was the depth of feeling around the topic area. This was evident not only from people's willingness to be involved in the study but also from comments they made in the interviews. Harriet, a recently-qualified therapist, complained that many GPs had a limited understanding and even interest in speech and language therapy. She was keen to get involved in the research because of this, as illustrated in the following exchange:

> The number of children who are still coming through the door not being able to say an 's' or and 'r' properly is incredible - and referrals from doctors who say 'This child doesn't speak properly'. No description about what's going on. And then going to my own GP who said 'Speech and language therapy is a closed book to me'. I thought well if you don't know and you're a source of referrals for us - and now they've become fundholders where does that leave us? And I just find it frustrating. And I mentioned it to - I can't remember who I was talking to - another therapist - and she said 'Well unless we offer GPs cheese and wine parties they won't come'.
>
> *Yes, yes. That's a famous line about offering them cheese and wine.*

I find it incredible. And it annoys me a lot.

It annoys me a lot too as you can see by what I'm doing now!

Exactly. That's why I thought I'll definitely get involved in this.

A letter confirming the time, date and place of the interview was sent together with a summary of the background and aims of the research. I interviewed most of the women and men in their places of work or in their homes, though two therapists came to my house at the end of their working day. The interviewees were asked whether they would mind being tape-recorded. I offered two reassurances - that if there were topics of a particularly sensitive I would, at their request, turn off the tape-recorder and also that I would send them a copy of the interview transcript which they could amend if they so wished.

Consonant with Oakley's approach to interviewing, I adopted a stance in which I was prepared to discuss my involvement with the research, including details of my professional career and how I came to choose the research topic. In line with Oakley's belief that there is 'no intimacy without reciprocity' I resolved that if people asked questions about my personal or professional life I would disclose such information. In common with Greed (1991) who is both a woman surveyor and a researcher of woman surveyors, I attempted to conduct the interview as a two-way process, for as she states:

> I see my research as a two-way process of interaction and sharing between myself and the other women. In particular, in trying to encompass both the professional and personal elements of their lives in my research, I need to be willing to give as well as to take. If I expect women to tell me what their lives are really like at a personal level, they expect that in return I will share with them information about my personal life and feelings (p.95).

During the course of the interviews I commented on findings from the review of the literature if this seemed relevant. This allowed my subjects to agree with or refute theoretical positions expressed in the literature. It also permitted them to comment on hypotheses which were emerging during the fieldwork. In order to make explicit my own views the transcripts contained a verbatim account of the dialogue between myself and the participants. It should be noted at this point that in the writing up of the results I included my own speech in some quotes to illustrate how my comments

and questions may have acted as prompts to interviewees' responses. Following the interviews, demographic details were noted down including age, marital status, number of children (if relevant), ethnic background and year of qualification. Participants were told they would be sent a summary of the research findings once the thesis was completed. Field-notes were kept during the course of the empirical phase of the research. The interviews ranged in length from one hour to ninety minutes.

Analysing the data

The analysis of the transcripts began with the completion of the first interview, for it was my intention to allow my theoretical position to be modified as I collected the data. During this period I continued to explore emerging themes. The 'messiness' I experienced in analysing the data is described by Beverley Skeggs (1994) in her account of doing ethnographic research:

> I usually concoct a multitude of different theories, using them when appropriate, ditching them when not, reworking them to construct explanatory frameworks. I always ask: 'could this theory say anything to me about my life or about the lives of the young women?' (p.82).

Added to this was an acute sense on my part of imposing an interpretation on the data which would reflect my view of the problem. Perhaps my sensitivity to this was heightened owing to the fact that, as mentioned earlier, I was the first speech and language therapist to raise a feminist agenda and was thus placing myself (at least it felt so) in a vulnerable position. I will return to the issue of interpreting research findings in section 5.4.

As described in Skeggs (1994), I worked neither from the ground up in inductive mode as described in Glaser and Strauss (1967), nor did I seek to 'test out' my hypotheses on the basis of the empirical data. My approach was to combine the two approaches, working backwards and forwards between theory and data. Based on the life-history format of the interviews, a logical starting point was to divide the data into three parts for analysis: people's reasons for 'choosing' speech and language therapy as a career, experiences of their professional education and their subsequent career paths. Each of these was then divided into sub-categories, some of which

emerged as unexpected but unifying themes and others which appeared relevant to theories which had already been raised.

These categories were further sub-divided into smaller categories until all the data had been analysed. I then attempted to 'merge' the data with the principal themes of the literature review. However in writing up the research I found myself frequently referring to the original transcripts rather than the data analysis, the reason being that selecting 'bits' of data meant inevitably that the context of quotes became lost in the analysis. I also found that my conceptualisations changed as the writing progressed so that the categories I had developed earlier were not necessarily relevant to my developing theories. I became highly familiar with the transcripts in the course of the analysis so was easily able to access supporting examples of different themes as and when necessary. It became apparent that my familiarity with the data was the biggest advantage of going through the lengthy process of formally coding the transcripts.

5.4 Responses and reflections

Responses to the field-work - the interviewees

I wish to discuss a number of themes in relation to the interviewees' responses to the research, including reactions to the interview situation, feedback after the interviews and worries over confidentiality. In terms of the interviewer-interviewee relationship, my experience coincided very much with that of Oakley (1981) in that in most interviews, particularly when I visited people's homes, I was not offered just the minimum of hospitality. I was given a drink on all but one occasion, many people offered a snack and on one occasion I was invited to join a therapist for supper. A number of subjects 'asked questions back' both about my experiences of working as a speech and language therapist and my personal situation. As stated earlier, I made no attempt to keep this information hidden.

In common with other researchers (see Marshall 1994, for example), I was taken aback by the level of trust established during the interviews and the degree to which people revealed often highly personal information about their lives. This information

generally came to light during the interviews, however, on several occasions I was asked to stay for a drink after the interview during which time other details were disclosed. Owing to the sensitive nature of some of the information it became particularly important that the data be handled with great care in the analysis and the writing-up stages of the research. This highlighted my responsibility as a researcher, as I wrote in my field-notes on 5th February:

> In this interview I was told highly personal information over coffee after the interview. Is this a result of sharing information about myself? I feel a responsibility with this information which is so private that I was told that 'not even my friends know'.

It was evident that a number of interviewees enjoyed the experience of being interviewed, a finding also reported by Phoenix (1994) in her study of mothers under twenty. After her interview one therapist described the experience as 'cathartic'. On another occasion I inadvertently left the microphone switched off thus failing to record the interview. I returned home and with great embarrassment rang the therapist to explain what had happened. On asking whether she minded being interviewed again she replied, 'What talk about myself for an hour again? Of course!'. I also received comments on several transcripts and a card either to say people had enjoyed the session or to wish me good luck with the study.

Although I attempted to establish a situation which minimised the power differential between myself and the interviewees, it was clear that in some interviews my theoretical or political position differed from that of my interviewees. One participant, in particular, expressed concern that I was making too much of the issue of women and that given the considerable progress which had been made this was no longer as valid. Kelly et al (1994) raise the point of what is to be done when the understanding of the researchers and their interpretations of accounts do not coincide with or threaten the perceptions or coping strategies of the research subjects. They argue that it is possible that some women hold anti-feminist viewpoints and that in general 'We cannot presume common experience or perspective with women participants' (p.38). This again raises questions about interpretation which I will raise in the latter part of this section.

An important issue raised by the respondents was that of confidentiality. This became evident in the way in which one respondent took care over her choice of words which could potentially reveal her identity. She also asked me how I intended to analyse the data. Eight people returned their transcripts with small changes, generally removing an anecdote which described a sensitive or emotive experience. I also received a letter from one interviewee which referred specifically to worries over confidentiality, for instance, she felt that descriptive passages of a certain educational establishment would render it identifiable. These concerns made me highly conscious of the confidentiality aspect of the study and caused me to reflect on how I would write up the data.

Other issues occurred to me which respondents had not raised including the point that relatively small numbers of people work in some specialisms. Thus even if pseudonyms were used, there was still a danger that confidentiality may be compromised. Interestingly, Greed (1990) does not raise this as a major issue in her work on surveyors. I suggest this is because surveyors have many different employers unlike speech and language therapists who work mainly for the NHS. It is therefore likely that professional networks are particularly strong in the latter occupation, rendering confidentiality in this type of study harder to maintain. I attempted to rectify this situation both in the fieldwork and in the writing-up stages of the research. For instance, I did not tell therapists who had nominated them for interview if the person who had given their name wanted to remain anonymous. Another strategy was to give people the opportunity to read their transcripts and comment on the way the data had been handled. In writing up the research I did not provide precise demographic details of the respondents including exact year of qualification, ages and ethnic background, nor did I divulge people's clinical specialities in highly specialised areas.

Reflecting on the research process - the researcher

Issues of bias in interviewing and in analysing data have already been highlighted. However, it was during the writing-up phase of the research that I became most aware of my power as a researcher. This is evident from the 131 pages of analytic memos I wrote during the writing of the thesis. I wish to use extracts from the memos to highlight some of my concerns including the 'responsibility' involved in interpretation and worries over taking a 'feminist' position. I believe that my position both as a researcher and therapist heightened my awareness of the responsibility of interpreting the data. On 5th May 1997 while writing the first draft of Chapter 1 I wrote:

> I think one of my major problems is being true to the people I interviewed, as in my analysis I am up against making selections according to my own interpretations/ideas while feeling I can't let people down.

I suggest that a researcher who approaches her subjects as an 'outsider' has a different relationship with them, in that after the research she can leave 'the field'. In my insider-outsider position I was more likely to receive formal and informal feedback on my research and feel that such a role imposed on the researcher a greater sense of accountability. The extract quoted above seems to highlight both positive and negative aspects of this; on the one hand there is 'responsibility' but on the other, emotional involvement which inevitably leads to reflection (and often painful) soul-searching.

My fears of interpreting the data were compounded by an awareness of the difficulty discussed earlier in finding a 'fit' between my theoretical position and the data. At times there appeared to be an enormous gulf between people's everyday experiences and the theories contained in academic writing. On 15th May I wrote:

> I keep thinking the data is not really corresponding with my 'theories' of what is going on. I am worrying about how this is all going to come out and what it is I am really trying to say. Is there a logic to this? Is there a coherent story?

My worries over adopting a feminist perspective were partly exacerbated by the fact that a feminist agenda was new to speech and language therapy but also by the point raised earlier that my views were not shared by everyone. There seemed to be a

tension between the political goals of my research and the perspective of some of the participants. At the time of trying to resolve this issue I was reading Barnes' view of disability research in which he argues there is no middle ground in researching oppression; academics and researchers can only be 'with the oppressors or with the oppressed' (Barnes 1996:11). How could I reconcile people's denial of gender as crucial (or so it seemed to me) with my own view that it was central? After my reading of Barnes I commented:

> And that is where I am having difficulty. *You are a feminist? A feminist? We don't want feminists here! We've got over that one.*

In 'making sense' of research material Holland and Ramazanoglu (1994) point out that no analytical technique can defuse the social nature of interpreting data. They suggest the process of interpretation is 'both positive and creative, but also flawed in the sense that we can never be sure that we have got it right' (p.145). Holland and Ramazanoglu argue that some form of reflexive interpretation is essential in order to claim any validity for our conclusions. Even then they suggest that 'Our conclusions should always be open to criticism' (p.146). I have been acutely conscious of my power as a researcher through the many stages of the research and the fact that this problem remains far from resolved. I take heart from Holland and Ramazanoglu's comment that there are '.....no stable rules of validation which can ensure that feminists always know best' (p.146).

5.5 Conclusion

In this chapter I have explained my choice of a qualitative approach to researching speech and language therapists' career by means of in-depth, face-to-face interviews. Furthermore, I sought to show how adopting a feminist perspective would be beneficial to the project. No attempt has been made to depict the fieldwork as linear, orderly and free of problems. Rather, in trying to write a reflexive account, the problems as well as the successes were highlighted and explored for what they could reveal about the research process.

The issue of power in the researcher-researched relationship was raised, particularly as it affected the process of interpretation. I feel my position as an 'insider-outsider' has made me more aware of the power invested in doing research, and though this situation is in a sense problematic it has brought a level of accountability to the study. I would agree with Beverley Skeggs (1994) that close involvement with one's research subjects (in my case as fellow professionals) make it difficult to 'theorize or practice solely in an ivory tower or a vacuum' (p.88).

A further issue was that by taking up a feminist stance I was choosing a particular position rather than placing myself on 'neutral' ground (if indeed this is possible). This meant that there could be a potential conflict between my perspective and that of some of the therapists I interviewed as I described in section 5.4.

The chapters which follow parallel the life-history format of the interviews. Chapter 6 explores reasons for choosing speech and language therapy as a career and Chapter 7 considers the interviewees' experiences of their professional education. Chapters 8-10 are concerned with their careers since qualifying.

Chapter 6

'Choosing' a career

6.1 Introduction

Chapters 2-4 highlighted women's problematic relationship with science in terms of their lower (but increasing) participation in scientific work compared with men's. Caring, on the other hand, has been typified as an activity uniquely suited to women. This is the reality for many women.

In this chapter I explore this division of labour in relation to factors which influenced the career choice of my interviewees. I consider to what extent expectations of male and female roles are reflected in these factors. I also consider to what degree the participants themselves felt their career choice was influenced by gender.

The chapter begins by looking at participants' roles in providing care in the family and the community. I then look at their educational backgrounds, subject choices and career options and specific reasons for choosing a career in speech and language therapy.

6.2 Experiences of caring in the family and the wider community

Many of the interviewees were conscious of the fact that opting for speech and language therapy stemmed from their experiences of caring for others. This section examines the nature of people's caring roles, the extent to which these were seen to be related to gender and how these early roles led to people's later career paths.

The accounts showed that a broad range of activities were undertaken which can be described as 'caring' or 'helping'. Most of these were undertaken on an unpaid basis. The nature of this work echoed the findings of the research discussed in Chapter 2 which highlighted the social, emotional and intellectual aspects of caring work as

well as the physical. Several therapists described caring for children during their girlhood both in the family and in the community. Jennie, who qualified in the early eighties, cared for her nieces and nephews. She emphasised the confidence she gained through carrying out the physical aspects of childcare:

> I mean I'd always done bits with children and always enjoyed being with children.
>
> *What had you done with children before that then?*
>
> Well you know anything to do with babysitting. I had three nieces and nephews and spent a lot of time with them and took them out and about and things like that. I liked children and I think at that age most people do really, don't they - or girls do anyway, I wasn't afraid of children. I topped and tailed them from - because there was quite an age difference between myself and my brothers so I topped and tailed his kids from quite an early age. I just felt quite comfortable - I wasn't afraid of children - I could change them, wash them, look after them and all that kind of thing.

Many accounts described a broader range of activities carried out in caring for others. On a number of occasions this involved caring for siblings with impairments and disabilities. For Maxine, whose younger brother had a stammer, this entailed taking on a protective, helping role from a young age:

> I've heard lots of stories about the frustrations and people thinking my brother was stupid and apparently I used to be very protective of him and would try and speak for him and do everything I could to help him. But it was very painful. He socially had lots of difficulties and you know...

Similarly, Mary recounted teaching her brother to read because he had missed much of his schooling:

> ..... he left school unable to read properly. I can remember teaching him. He went to secondary modem school because he missed so much schooling. He left school hardly able to read. I can remember teaching him when he'd be about fifteen and - oh dear it was terrible - he hated, I hated it. But I really taught him to read.

Chapter 2 discussed the significance of women's role as managers of personal relations. This was true of several interviewees including while they were growing up. There could be parental pressure to take on this role. Maxine described how she

was encharged with the responsibility for organising her younger brothers, for instance, reminding them about birthdays:

> ..... being the eldest as well. I was always the responsible one, organising my brothers, you know. If it wasn't for me then they wouldn't remember mum's birthday. And even in adulthood years later I'd get 'Don't forget to remind them about so-and-so'. How long does this continue?

While most people's experiences of caring involved looking after people younger than themselves, there were instances of girls providing emotional support for older family members, including parents. Susie, for instance, found herself trying to resolve her parents' relationship difficulties on several occasions:

> *Do you think you were cast in a role of facilitator of communication in the family?*
>
> Yeah. Especially with any of the conflict. If there was a row - I mean several times it was mum with her bags at the door and I was clutching on to her phoning dad with one hand and stopping her with the other desperate to keep everything together and they kept themselves together.

Earlier in this section Jennie commented on the fact that young people, particularly girls, enjoy looking after children. Several other participants remarked that caring for others is a role which tends to be associated with women rather than men. This was especially true thirty years ago when women were more likely to stay at home after having children. Margo felt that the expectation to care for siblings was greater at that time:

> You were only just sort of coming out in the sixties - when I started in the early seventies we were only just coming out of the era where women were at home looking after children. I mean I was one of a large family of six children so I did a lot of caring. I was the oldest. So I looked after four brothers and a sister and so there was that side of things.

Jude felt that being a woman was a major factor which influenced her to do medicine (she later switched to speech and language therapy). She recounted that her motivation to enter medicine derived from a need to care and 'a need to be needed'. This was further reinforced by the birth of her younger brother who had Down's Syndrome. She described how her adolescence was taken up with helping him develop:

You explained how you made your choice of career but do you think it had anything to do with being a woman?

Oh enormously, absolutely, without any doubt. My whole - having discovered later that my whole emotional drive to do medicine was from a position of caring and it was from the position of - I have a younger brother who has Down's Syndrome and I was twelve when he was born. So my entire adolescence was taken up in the task of helping him develop. And I think I really do think, although prior to him being born I was very clear I wanted to do that, I think there was a very strong emotional pull that was then reinforced by his birth. So even before he was born I needed to care, I needed to be needed....

While caring was associated with womanhood by a number of interviewees, Mike's experiences indicated that it was not only women who took on caring roles as young people. He pointed out that part of his motivation to do speech and language therapy stemmed from his involvement with children as a teenager:

I mean - throughout my teenage years I was looking after children and working with children on a voluntary basis, that sort of thing and decided I'd really like to work with kids.

Other therapists drew links between earlier helping or caring roles and their decision to enter a caring profession without making explicit references to gender. Maxine, for instance, thought that she wanted to help her brother and that going into speech and language therapy was a way of helping other people. Similarly, Anna felt her experience of motherhood and of being a hospital volunteer had influenced her decision to go into speech and language therapy:

..... working in hospital and you know you just immediately start feeling protective of people who can't communicate. And I'm sure it's to do with how you feel about your own children.

Really?

Oh I think so. I think I just got more sympathetic and empathetic after having the children.

Ann had also worked in a voluntary capacity, in this instance working alongside a speech and language therapist. The themes of teaching and caring came up again in this context:

I think I enjoyed interacting with the patients. I enjoyed that part of it very much. I suppose I enjoyed the combination of the teaching role plus a caring role. It sort of seemed to cut across teaching and medicine in a way quite nicely.

This section has discussed the importance of caring roles undertaken in the family and community and the influences these had on people's subsequent career paths. While the gendered nature of caring was highlighted there was evidence of some of this activity being undertaken by men as well as women. The next section examines the educational backgrounds of the research participants in the context of ideological influences on male and female roles as discussed above.

6.3 Gender and educational experiences

The educational background of the research participants reflected a by and large middle-class upbringing. Thirty-three (83%) were middle-class and seven (17%) were working-class, as determined by their fathers' occupations. While there was no standard question asking people about the type of school they attended, eighteen proffered this information spontaneously. Table 6.1 shows that the largest group were those who attended single-sex grammar schools.

Table 6.1 Educational backgrounds of eighteen study participants

Type of school	*No.*
All-girls' grammar	8
Convent	2
Co-educational grammar	2
College	1
Boy's grammar	1
Secondary modern	1
Educated abroad	3

Given the high proportion of people who attended grammar schools and the middle-class bias of the sample, it appears that the educational experiences of the study participants were relatively privileged compared to the population as a whole. The findings appeared to bear out the research in Chapter 2 which indicated that girls' educational attainment and degree of self-confidence correlates with type of school attended. Several participants who went to single-sex schools spoke of the heavy

emphasis placed on academic achievement. Chris, for instance, noted that at her school in the seventies girls were encouraged to pass exams and go on to university:

> .... it was a grammar school it was streamed north, south, east and west and it was kind of expected that people in north and south would go on to university. That was the kind of expectation. The people in east and west tended to do the more craft, practical things like cookery, needlework, the usual stuff people do. Whereas in the north and south streams of the school you really weren't encouraged to do that. It was an academic hothouse and you were encouraged to pass exams.

Similarly, Jennie noted that her school had....

> ..... an active bias towards university entrance and UCCA and anybody who didn't fit that - the people who went on to secretarial college were ignored completely.

Jeanette went into speech and language therapy as mature student having left school with few formal qualifications. Her experience of secondary modern school in the sixties contrasted starkly with Chris and Jennie's experience. Failure at the eleven-plus stage had long-lasting implications for educational opportunities, with few pupils going on to take 'O' levels:

> .....it was all about the time when education - you know it was the eleven-plus. If you didn't pass the eleven plus you went to a secondary school where you didn't get the opportunities. And so that's what happened - I went to a secondary school - great disappointment to my father and my grandmother who brought us up. And did well, actually, at the secondary school but didn't get the opportunities really -you didn't really take 'O' levels at secondary school.

Jeanette explained that like many girls who attended secondary modem schools she was encouraged to learn secretarial skills. She lacked the confidence to consider areas such as business because of early school experiences:

> *When you retrained you didn't think of going into business or accountancy?*
>
> No, because the patterns are set early on and I just didn't feel I had the intelligence - that was the early schooling problem - that you lose a whole lot of confidence in your abilities. So no, I didn't think of going into industry or finance or anything like that.

In spite of the emphasis placed on academic achievement at all-girls' schools, many people going through secondary education up until the eighties spoke of higher expectations placed on their brothers to succeed academically. Girls, on the other

hand, were frequently expected to tailor their ambitions around their assumed future roles as wives and mothers. Caroline, who went through secondary education around the late-sixties and early seventies, reluctantly acknowledged that her parents who were living abroad sent her brothers back to the UK to boarding school because their education was deemed 'slightly more important':

> I went to a local school. My brothers all went home to boarding schools but my parents couldn't afford to send all of us.
>
> *Why did the boys go?*
>
> Tradition. They felt that the boys' education was slightly more important. They also felt that - well that's a bit unfair. They probably wouldn't like me to say that. They'd hate that.

Younger therapists similarly noted a tendency for their families to encourage their brothers towards academic success. Georgia stated that her brother was 'pushed' academically more than her and her sister because of his gender rather than his superior ability:

> I don't think I was pushed so much by my parents as say my brother was because my brother is two years older than me and he was pushed along the academic line probably more so than I was.

Including for therapists experiencing secondary education in the eighties, the ideology of marriage was still powerful. In common with Georgia, Beth noted that the focus on her brother was 'academia'. Education for girls was emphasised less in her family because they were expected to have children:

> ..... for men education was more important. I mean a lot of that came from my mother as well - education was very important for men, and women were always going to go and have children anyway.

She explained how these attitudes influenced how she saw the future, cautiously admitting that she thought she would be 'looked after' by her partner:

> I didn't think of my future. I didn't think of careers. I'd come from a very middle class background. Although I hate to admit it I think I thought I would always be looked after by my partner that I would ultimately have.

The data thus appear to indicate that although many of the participants in this study experienced pressure to succeed academically, the ideology of the family continued to be an important influence on the way they saw their futures.

6.4 Subject choices in education

Chapter 3 pointed to changes in education whereby female students are entering science courses in increasing proportions. This trend substantiates other research which shows that the traditional gender divide in education between arts and sciences is breaking down slowly.[20] However, although girls have traditionally opted for arts rather than science subjects at school, there were indications from these data that the speech and language therapists who took part in the study pursued sciences in higher proportions than girls in general. Twelve participants gave their A level subject combinations, These were analysed according to whether they were all sciences, a combination of arts or sciences or all arts. Five people took only science subjects compared with four who combined arts and sciences and three who took only arts subjects.

Of interest is the fact that three of the five therapists who took science A levels were at school in the sixties and seventies at a time when girls were less likely to opt for science subjects. This sample is therefore is atypical in terms of girls' subject choices, being biased towards the sciences. This is to be expected in that speech and language therapy education incorporates a large element of science, as was seen in Chapter 4 and as I will discuss in Chapter 7 in relation to professional education.

Rather surprisingly, of the four interviewees who studied speech and language therapy at postgraduate level, three had degrees in arts subjects and one in phonetics. One educational establishment, which has been running a postgraduate course since the seventies, has a tradition of admitting students from backgrounds in both the arts and science. The reasons for this can only be speculated on here. This policy may reflect a conscious philosophy on the part of the university to admit people from

different backgrounds who would bring a broad range of skills into the profession. It may also relate to labour market issues and the possibility that science graduates are more likely to be attracted by better career opportunities in industry.

Despite the fact that people with diplomas or first degrees were more strongly biased towards the sciences at school than girls in general, their accounts of their education were not unproblematic in relation to science. There were issues regarding subject options available and actual and perceived ability in science. Sarah recalled that it was still the trend for some schools in the seventies not to allow pupils to mix arts and sciences in the sixth form. She had to go to technical college in order to do a combination:

> ..... in those days you could get in on 2 'A' levels so I did biology and English and they weren't on offer - sciences and arts were very separate in schools, so that's why I had to go to a technical college to do those

Clare explained that A level options in her girls' school in the late seventies/early eighties were still stereotyped. The scope for combining A levels was limited and 'male' subjects such as engineering and mechanical drawing were unavailable. Again, pupils wanting to mix subjects had to leave the school:

> ..... it was not a huge school and therefore the choice of 'A' level subjects. You didn't - well you did zoology, botany, chemistry. There wasn't - well physics oh yes OK. But there was nothing more - nobody had opportunities for technical drawing or those sort of engineering. There was nothing like that.

Though A level choices in the sample were biased towards the sciences, the numbers of people taking the typically male subjects of mathematics and physics were small. Seven studied biology, three studied maths and two took physics[21].Recalling her education in the fifties, Adrienne said that she was 'no mathematician' and found physics 'hard'. On the contrary, she found biology easier and more interesting:

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[20]Arnot et al (1996) note that the gender gap in favour of female students in Arts and Humanities A level entry is now decreasing. Young women are also closing the performance gap in A level subjects in which there are proportionately fewer, e.g. physics and mathematics.

[21]Payne (1980) recalls how in the sixties most girls 'chose' biology at grammar school. Fewer did chemistry and only a small minority did physics. Arnot et al (1996) note that women now outperform young men at A level biology but young men achieve higher performances in maths, chemistry and technology.

> ..... things like anatomy and biology at school and neurology. That sort of thing I found easy. Physics is another kettle of fish. Because I was going to say I'm no mathematician which again I think is quite common in our profession! People say Oh these stats. I can't cope with the maths. And certainly I found physics hard. But I suppose I was interested in it and it did come easily, biology. And it was fascinating.

Other interviewees also perceived themselves to be not 'good at' physics and chemistry, including Ann who was required to do science as part of an Access course in the nineties:

> ..... it was an Access course in science and it really did tax me intellectually, because although I loved biology and that side of science I had to do physics and chemistry as well, which aren't particularly my strong points.

Many women, including those who went through schooling in the eighties perceived themselves to be less able in science and mathemetics. However, it is questionable that these self-perceptions corresponded with 'real' ability. Beth said she saw herself as a female underachiever unable to do a mathematics or science degree:

> I think I perceived myself as a female, an underachiever and not able to do many degrees that are mathematical or scientific.....

This was in spite of the fact that speech and language therapy degrees comprise in the main of scientific subjects.

The analysis presented here suggested a bias towards science subjects at A level amongst speech and language therapy students, including those from earlier generations. Despite this apparent difference from girls in general, there were experiences of gender bias in secondary education in the seventies and eighties including restricted option choices and having to 'choose' between science and arts. Despite the science emphasis of speech and language therapy education, many therapists had self-perceptions of difficulty with science. This is not surprising given gender-differentiated performance in science education as was highlighted in Chapter 3.

6.5 Gender ideology and career choice

Chapters 2 and 3 showed that though occupational segregation by sex persists in the labour market this pattern is to some extent breaking down. As regards the professions, there is a trend for increasing numbers of women to enter the male professions including the health care occupations of medicine, pharmacy and psychology. There has also been an increase in the numbers of female undergraduates in the physical sciences, engineering and technology. Speech and language therapy, however, remains overwhelmingly female, with only a one percentage point increase in males over the last 25 years (from 1% to 2%).

This section examines the extent to which gender ideology was significant in terms of the options presented and ideological pressures exerted around the time the interviewees 'chose' their career. Pat's account of all-girls' schooling in the sixties indicated that although girls received good science teaching they rarely took science up on leaving school, usually opting for arts degrees, teaching or nursing. At that time law or accountancy were unusual:

> I went to an all-girls school and there were obviously certain things that were acceptable. And I suppose also thinking back it would have been fairly trail-blazing to be a lawyer or an accountant at that time - by no means unheard of. But obviously the most conventional things were obviously nursing, you did a history degree, became a teacher - teaching in all its guises.
>
> *So it was nursing, teaching....*
>
> You did your degree in something nice - history, geography - exceptional ones would have done sciences. Although sciences were quite well taught in the school I went to you didn't find many people ending up doing that.

There were indications of continued stereotyping as regards careers options in the seventies. Despite the heavy emphasis at Chris's school on academic achievement career options were limited. Those that she did mention were stereotypically 'female' careers:

> ..... the school I was in was very limited in terms of options - it was an all-girls grammar school so what they were pushing for really were medicine, teaching or nursing and those were the three careers that were open to you. Anything outside that really very little was known about.

Of interest is the addition of medicine as a viable option, probably reflecting the fact that medicine was becoming increasingly acceptable as a female career at that time.

As regards career options for boys, Mike commented that speech and language therapy was not considered a viable option:

> ..a definite no-no as regards to career counselling. I was told it really wasn't a profession for a man.

It was seen as a female profession along the lines of nursing. Interestingly, amongst the career options deemed suitable were teaching, another 'female' profession and banking:

> .... they thought it was a female profession - you know it was a caring profession - a bit like nursing and I should be thinking about something a bit more male-orientated.
>
> *Like what - what did they suggest?*
>
> Well you know - the classics sort of like teaching - that was an option or things like banking - you know good solid stuff!

There was evidence from the data of gendered expectations in terms of career options. These originated from pressures from school, family and, on occasion, the church. Pat commented on the way in which girls' career aspirations were tempered by expectations that women would not work for long (presumably on the assumption that they would leave work to marry and have a family):

> I think it was expected that most people weren't going to have too much of a career, I think. You weren't going to be finished off - it wasn't quite like that, but on the other hand it was probably expected that you wouldn't work for that long.

Several people going through school in the seventies spoke of school and family influences on which jobs were 'appropriate' for their assumed future roles as male breadwinners/female housewives. Louise, for instance, received offers to do both law and speech and language therapy, finally deciding on the latter owing to social pressure to marry. Implicit within her account is the idea that speech and language therapy is an acceptable career for a woman; that it is secondary to a male career and

can be easily combined with a family. This also implies that the converse is true of careers in law:

> I did get a place at..... *(university)* and at the time all my friends had boyfriends - it's ridiculous - well it sounds like it now - it's ridiculous - getting engaged to get married, really crazy. There was this social pressure again in the sort of area that I came from that women's careers were second to men's and I thought Well it would be nice to have something you can fall back on if I did get married and have children. This sounds awful - crazy.

Not surprisingly, income was stressed as an important factor for boys when choosing careers. Mike pointed out that within the culture of boys' schools speech and language therapy was not seen as an attractive option:

> I think there's a lot of stereotypical stuff floating around about it being a female profession still which I think a lot of men are put off by. I think the pay then was certainly a big issue and you know how it is - well maybe you don't - this sort of competitive thing that's developed, particularly in boys' schools about good salaries and nice car and this sort of thing and if you sort of bought into that whole way of looking at things then speech therapy wasn't exactly an attractive option.

There was evidence that the ideology of marriage persisted into the late eighties. Rose recalled how it was said to her that speech and language therapy was a good career for a woman since it was a useful second income and a good job 'to keep you busy'.

Also in keeping with gender ideology regarding women's 'appropriate' roles' was pressure to enter a career which would in some way help people. Sarah, who attended school in the seventies, was aware of being channelled into such a job. She was discouraged from becoming a drama teacher because it was 'too frivolous':

> ..... they wanted you to do something that was for the good of mankind - you know that it was rather frivolous to be a speech and drama teacher or elocution, etc. So I was sort of pushed along the line of something that did good for people and I think I was looking through a career book and found SLT or speech therapy as it was in those days and I thought ah, yes - I could help people as well.

The above evidence portrays speech and language therapy as a 'feminine' as opposed to a 'masculine' career choice. A further stereotype was that a career in a female occupation was not an academic option. Margo, for instance, described her father's attitude towards her career. On the one hand he would not have prevented her from

going into law, as he had done, but on the other he had a low opinion of 'women's brains'. Her comment seems to imply that law is for intelligent women, possibly contrasting with the ability needed to go into female careers such as speech and language therapy:

> .... my father was although he was a very Victorian person wasn't going to put any stops in the way of law. He recognised that women could go into law, although he doesn't think very much of women's brains, I don't think. So I think there's a little bit of a split there.

There was much evidence that the stereotypes with which career options were associated had limited correspondence with reality, especially with regard to the personal circumstances of the research participants. Careers such as teaching, speech and language therapy and nursing were deemed to be useful second incomes. This was not the reality, however, for a significant proportion of interviewees. While information as to the relative importance of the speech and language therapy salary within each household was not obtained, it is of note that a significant minority of interviewees - fifteen in total - were not living in marital partnerships. Eight were single, four were widowed and two were divorced. Like many women, Jeanette had not expected to be the main breadwinner but her situation changed through personal circumstances:

> I honestly used to think I'm glad I'm not a man. Because I know that if I was a man I'd have to work for the rest of my life to support the family. As it happens I'm a woman and I'm having to do that. But that was my perception and my expectation was that I wouldn't have to work for the rest of my life. And the goal-post has been changed unfortunately.

Jeanette commented that women were now returning to work after having children. It was no longer the case that speech and language therapy was a useful career before having a family:

> .... the whole situation for women has changed - that you do have to go on working because of the economic climate. It's not often women stay at home and just look after the children and don't go back to work.

Contrary to stereotypes, speech and language therapy was not a career to which people could easily return after a period out of paid employment. A number of therapists highlighted the need to keep pace with theoretical and practical developments during 'career breaks'. Rachel noted that many changes had taken place while she was out of the profession. It took some time to regain her confidence:

> .... it's very difficult for people coming back into the profession like me. I mean I had no dysphagia knowledge. Dysphagia is a speciality which has only developed well, within the last ten years and it's very, very difficult for people coming back into the profession to find a course which encompasses all of that. Because what they need is a course which literally starts from the very basics - is a revision of the basics and then pulls back up and comes up to the higher level. Otherwise they shy off - they're too nervous because they feel lost, which is how I felt, certainly.....

It was also apparent that the labels 'helping' and 'caring' stereotyped occupations such as speech and language therapy which, as was seen in earlier chapters, incorporate skills across the science-caring divide. Arguably, solicitors may act in a caring capacity, by giving legal aid, through involvement in industrial tribunals and so on. However, it seemed that speech and language therapy was more likely to be considered a 'caring profession'. Louise perceived law to be competitive and academic. Her account implies that she thought caring work had neither of these qualities:

> I'm sure it stems from being a Brownie and a Girl Guide that my aim in life was to help people and be a caring sort of person. And I thought whilst academically I could do a law degree, I thought 'Well is that really me? Am I that sort of competitive person? I really think I'm more geared up to a caring sort of career'.

Given the entrance requirements of the course, the notion of speech and language therapy as not competitive or academic is questionable, particularly from the late seventies onwards when colleges were raising standards, as Annette recalled:

> ..... it was at the end of the second year because I remember us all feeling really shocked that they'd been allowed to do so much when you know they were basically told we don't think you're suitable, and because they hadn't got the grades it was good reason for getting them out.

In terms of comparisons with other careers, speech and language therapy was often seen as the next choice after medicine, as Clare pointed out:

> ..... it was medicine or nursing. But nursing - you didn't need a degree to do that. So academically I wasn't top end but I ended up with three reasonable 'A' levels which enabled me not to choose where I wanted to go, but have a reasonable overview of where I wanted to train.

The data indicated that during the sixties and seventies schools tended to encourage girls into stereotypically female careers and boys into stereotypically male areas with the exception of teaching. This pattern accords with the gender-segregated labour market as described in Chapter 2. Female careers were seen to be suited to girls because they provided a job 'to fall back on'. Female occupations were deemed unsuitable for boys in large part because of the low pay. The idea of speech and language therapy salaries as secondary was still evident in the late eighties. A further expectation was that girls should enter a career which would 'help' people. There was an implication that such jobs did not require an equivalent level of academic ability as the male professions, for instance, law. This section drew attention to the danger of stereotyping the female professions as 'pin-money' and non-academic. These perceptions have limited correspondence with reality.

6.6 Why speech and language therapy?

In this section I focus on why people opted for speech and language rather than other occupations, in particular the male-dominated professions. These decisions are discussed in the light of research in the literature review.

In view of previous sections in this chapter it might be expected that a major attraction of the job would be that it involved working with people. While some interviewees made no reference to 'helping' or 'caring', many people cited this as a reason for going into speech and language therapy. The significance of caring will be discussed by reference to a number of interviews before moving on to discuss the ambivalences people expressed around this.

Rachel recalled that her interest in communication had been sparked by a film, similar to the story of Helen Keller:

> I had always been very interested. I saw a film on television when I was about - I don't know - 15, 16. It wasn't Helen Keller but it was a Helen Keller-type film. One Sunday afternoon - I mean I can still remember the film - it was a very old-fashioned - it might even have been a black-and-white film. And it was about a deaf-and-dumb girl going to a special school and being taught how to communicate. And I was terribly taken with the whole thing and really wanted to do it but didn't know what it was called.

She explained that the idea of helping someone communicate was still a strong motivation:

> It was absolutely the fact that there was - someone was helping someone and I think it was - and I think that holds true right up until today - it's this fact of doing something positive and achieving an end result - that something you did you could see had an effect. And it was the human effect. It was the emotional satisfaction of seeing this person able then to communicate.....

Many interviewees had rejected the male-dominated professions such as accountancy and law because they were not perceived to involve 'working with people', as Pat explained with regard to law:

> There was some pressure for me to do law but I was always much more interested in how people tick. And although you obviously deal with people as a lawyer or to some extent as an accountant, I didn't feel that was going to be as satisfying. I envisaged lawyers as people who sat in dusty offices and read rather dry tomes.

Maxine rejected medicine for similar reasons, noting that doctors tended to have limited contact with their patients:

> I really wanted a job where I was not going to see somebody one day and not see them again for six months. You know I wanted to be able to build up relationships with people.

Another aspect of caring work was that it generally involved co-operation rather than competition, the latter being generally associated with the male occupations. Beth had considered a career change to law, but was discouraged by the competition it appeared to involve:

I don't know enough about law but I imagine the client is an exercise and two solicitors fight the case to win and the fact that sometimes they don't believe in their client I find very distressing. So basically it's just about winning.

However, a number of ambivalences accompanied the strong sense that it was the people-based aspect of speech and language therapy which appealed. Several therapists were tentative about labelling the profession as 'caring'. Emma was reluctant to use the word at all because of the danger of stereotyping:

Have you any ideas about what you think it may be about this job that would appeal to women?

I suppose it's something that I haven't thought about before but having started work I mean it is quite easy in terms of job-share. I mean there is flexibility in terms of working hours, working part-time. I mean that could be - on a practical level that could be quite practical. I don't - I'm very wary of saying things like 'caring profession' and things because I mean I don't think...

What worries you about that?

There is a danger of stereotyping the profession, really or any sort of therapy-like profession.

For several people the word 'caring' evoked stereotypes of feminine behaviour including self-sacrifice, being 'nice', getting on well with people and having patience, stereotypes which were felt to be damaging to the image of the profession. Yet on the other hand there was a feeling that this aspect of the work was important. Georgia expressed this ambivalence:

..... it's the old scenario, isn't it? The old cliché - the helping professions and the caring aspect, I suppose and also I wanted to work with children in some capacity but didn't want to do teaching. So that was why I decided to go in the end.

It is a cliché about the caring professions, isn't it? But obviously that was something.....

Well I suppose it's all the stereotypes, isn't it? The old interview question 'Why do you want to do speech therapy?' 'Because I want to care for people'. But I suppose that must be there somewhere - not caring for people in the job that I'm actually doing but sort of helping people - trying to facilitate change in some way.

Speech and language therapy was generally characterised as a job involving relationships with people including a strong emotional element. Also of note was the fact that there were aspects of the work in which patient contact was limited, including research and writing.

The previous section pointed to the perception that speech and language therapy was not a demanding, academic option. This was evident in the way therapists compared the qualities required for speech language therapy with those deemed necessary for 'male' professions. A number of interviewees saw law as a subject which required good cognitive skills, including rationality and memory, traits typically associated with masculinity. Harriet, for instance thought law too 'dry' and 'by the book' and commented 'It's too logical! I'm not logical enough!'.

An attraction of speech and language therapy was the range of subject areas which it covered, including the science aspects which are traditionally less popular with women. Many therapists entered the profession because of interests which spanned the arts/science divide. Lynn liked the idea that it combined both medicine and education:

> I think I was struck by the fact that it combined medicine and education, so I was getting the best of what I thought was possible careers that I could have chosen.....

Interests in science included fascination with the intricacies of the body. Annette described how she became interested in neurology after being injured in a car accident:

> I was fascinated by the neurology because I had to see a neurologist and have all these different tests done to see what the effects of the knock had been. I remember feeling really fascinated and wanting to know what the state of my memory was and what the state of this was and just fascinated with the connections - why they were doing all these tests.

Rose's academic interests at school were in the sciences. She wanted to use these in an applied way:

> I wasn't that interested in science to actually want to do it as a job professionally. I wanted something where I'd be mixing with people and I think helping people as well, you know.

Another reason for choosing speech and language therapy was the fact that it did not appear to require mathematical skills. Lack of mathematics (or perceived difficulty

with the subject) led to the rejection of many of the male occupations. Lynn recalled being told that mathematics was needed to become an engineer:

> Somehow I didn't feel I had all the bits that - I thought about being an engineer as well. I remember that and doing maths - we had to do equations and being told by the teacher if you couldn't do these equations you couldn't be an engineer because that's the foundations for all the things they do.

Sally, who qualified in the sixties, felt optometry may have been an option, but the mathematical side to it did not appeal:

> Perhaps something like optometry - that seems to attract a lot of men, but then it's terribly mathematically-based and that wouldn't have suited me at all.

For eighties graduates, including Lynn, the lack of mathematical knowledge or skill does not entirely match with the reality. Graduates have been required to pass papers on research methodology and statistics in order to qualify since the early eighties. I will return to this point in Chapter 7.

The data showed that caring was a major factor in people's decisions to enter speech and language therapy. However, this label appeared to evoke negative connotations associated with stereotypes of female behaviour. In general, the job was characterised as one which involved co-operation rather than competition and close relationships rather than distance. Some people also perceived the work to require lesser academic ability and fewer stereotypically male skills such as mathematics. Male occupations such as law were seen to need the male qualities of academic ability, rationality, emotional distance, competitiveness and mathematical skills. These stereotypes were open to question on a number of counts including the fact that not all aspects of speech and language therapy involved patient contact. Furthermore, many people were attracted into the profession because it combined elements of both science and art.

6.7 Conclusion

This chapter sought to explore why people went into speech and language therapy in the light of gender stereotypes regarding 'appropriate' roles for women.

A number of interviewees felt their choice of career had been influenced by the fact that they had cared for others in a variety of ways in the family or community. Though involvement in caring was not confined exclusively to the female interviewees, several people were aware that their roles as carers or their 'need to care' was part of female socialisation. The findings of this research thus reflect the significance of caring work in women's lives as underlined in Chapter 2.

Though secondary schools, particularly all-girls' schools, stressed the importance of academic achievement, there was evidence including in the eighties, of more pressure on male members of the family to succeed academically. An analysis of sixth-form subject choices of a sample of study participants showed that an unusually high proportion pursued sciences relative to girls in general. Nevertheless, there was evidence of gender bias in secondary education in the seventies and eighties with restricted option choices and a divide between the arts and sciences in some schools. There was insufficient data to assess the impact of equal opportunities legislation from the eighties and nineties in this area. Though many people did study science, biology was the most popular subject and physics the least, a common choice for women in general, as was pointed out in section 6.4 of this chapter. Many people had poor self-images in relation to their competence in scientific subjects which is surprising given the scientific bias of speech and language therapy education.

The findings for the participants in this study show that the seeds for gendered career choices are sown early on during the formation of career aspirations for girls and boys. There was considerable evidence of gender stereotyping as regards careers options in the sixties and seventies with girls commonly advised to enter female areas including teaching or nursing. The ideology of the family continued to be a significant influence on young people's career aspirations, with evidence that girls

expected to marry and not to plan for their long-term futures. Careers were generally deemed suitable if they fitted around girls' future roles as wives and mothers. Boys, on the other hand, were encouraged away from these areas and urged to go into well-paid occupations such as banking. Assumptions around the female occupations were that caring for people was uniquely suited to women and required lower academic ability. While there was considerable ambivalence attached to the notion of 'caring', a major reason people opted for speech and language therapy was the people-based aspect of the work. This ambivalence is likely to be symptomatic of the undervaluing of women's labour in general.

Chapter 7

Professional education

7.1 Introduction

Chapter 6 indicated that the caring aspects of speech and language therapy were a prime motivation for entering the profession. I argued that ambivalences surrounding the notion of 'caring' derive from the low value placed on such work on account of its close associations with women.

However, speech and language therapy education, as I indicated in Chapter 4, focuses by and large on the scientific rather than the humanistic aspects of human communication. It was suggested that the status of the profession was linked to its identity as a scientific discipline rather than its role as a form of therapy. Chapter 4 also drew attention to the apparent widening gap between scientific theory and therapeutic/humanistic practice.

These developments are explored via study participants' accounts of professional education from the fifties to the nineties. Section 7.2 looks at historical developments in speech and language therapy education and section 7.3 examines the scientific content of the curriculum. Section 7.4 considers the practical part of the education, particularly its status relative to other parts of the curriculum. The final section explores the tensions between the theoretical, scientific element of the professional education and the practical, caring elements in relation to gender.

7.2 A changing curriculum?

This section looks at how speech and language therapy education has developed in terms of academic standards and the theoretical and practical components of the curriculum.

Chapter 4 drew attention to substantive changes in the education including the change from diploma to degree status in 1985, an increase in course entry requirements and the integration of the formerly independent colleges into the university sector. While all-graduate status represented a major development in speech and language therapy education, the data indicated that academic standards were rising some years before this. Paula described the sixties as a transitional period in the education. In common with Annette's experience a decade later (see section 6.5), colleges were keen to raise academic standards, with people leaving if they failed end of year exams:

> .....it felt like it was a turning point between people were sort of nice ladies going into speech therapy who weren't particularly academic and everybody started and everybody finished the course and maybe the standard of people going in wasn't terribly high, I don't know. And the turning point from that to it becoming more academic, more fussy about who went on the courses, and certainly people not completing the courses.

Sarah also drew attention to changes which took place during the run-up to degree status, noting that the profession was unsure whether it should be encouraging the 'academic slant' or the ability to 'communicate and get along with people'. She remarked that as someone of lesser ability academically she was 'more interested in doing the job', seeming to imply that those who were academic would not be interested in the clinical side:

> .....the academic slant was becoming more important than the ability to communicate and get along with people - I think there was a specific time when the profession was in a bit of a dilemma about what it should be encouraging about that time. And I think I represented the old type of therapist that perhaps wouldn't - didn't have three 'A' levels, didn't have quite the sort of academic interest - I was much more interested in doing the job and working with the people and felt I had a lot to offer.

Similarly, Pat observed that many of the people with whom she studied in the sixties would not have got onto the course with their A level grades. They were practically orientated whereas students now were more interested in the intellectual aspects of the job:

> .....not many of us would have got into the courses nowadays on the educational qualifications we had then, i.e. several of us had two 'A' levels for example. So that might have been questionable. But there would have been a lot of people who might not have wanted to carry on, I think, because on the whole people were very practically orientated. I think the

> big difference is that it appeals to people from a much more sort of intellectual point of view now.

This observation provides an interesting counterpoint to the findings present in Chapter 6 which showed that the majority of interviewees across the generations entered the profession because of its practical application. Given Pat's comment it might be expected that new graduates would be less committed to the applied aspects of speech and language therapy. This perception will be examined in the course of the chapter.

There was a perception that the theoretical component of the course had increased and that new graduates were aware of moves to 'intellectualise' the profession. A number of interviewees from the fifties to the late seventies remarked on the limited amount of theory on the course. There was also a sense in which the course was deemed to be undemanding. Several people qualifying in the fifties felt their education was limited including Mary who reluctantly described her course as 'paltry':

> I hate to say the word 'paltry', the training - but when I look back on it - yes it was paltry, because for a start there were no assessments when I trained. There was no such thing as linguistics.

Adrienne also remarked that her course was 'pretty basic' because of the lack of knowledge at that time about language. Though she enjoyed the course she described it as 'very-low key' compared with the education students now received. Pat noted that her education in the sixties was less theoretical and placed more emphasis on practical skills:

> .....*what do you think have been the main changes in the education from what you can see of the students now?*
>
> I think there is very much more theory. When I think back to what we learnt about dysarthria, we did do the neurological - the neuropathology in reasonable depth I suppose, but we spent a whole term if not more actually going through each sound, what the deviances or difficulties might be with that sound, how you would elicit the sound from each deviancy and how you would establish it. So very, very practical.

In Chris's opinion, her course in the seventies was undemanding academically and in terms of the volume of work required. She perceived there to be a significant difference between the diploma as it was then with the degree course:

> Doing the degree course as it is now is very different from doing the diploma course which was then three years. I have to say, I didn't at that time find the diploma course particularly academically challenging. I mean I went through the three years very comfortably with not doing a vast amount of work....

To what extent does the perception of an increase in theory match up with actual changes in the curriculum? The data indicated that from the fifties to the present, certain core subjects have remained on the curriculum: speech pathology, anatomy and physiology, neurology, psychology and phonetics. The seventies saw the gradual introduction of linguistics, statistics and acoustic phonetics. Eileen recalled the absence of linguistics on her course in the sixties. The later introduction of linguistics paralleled developments in clinical practice:

> .....when we were in our third year when they said 'You really must have some lectures on this!' I don't think it came into the exam. I think it was very much fitted - that they suddenly they thought...
>
> *This was important. In your practical work though were you working with language problems in children?*
>
> Yes, well I think we all worked very much - I don't think anybody was terribly sure what they were doing. I mean the speech bit was OK - except of course we didn't know too much about dyspraxia - so I think an awful lot of it was working on the articulation - what was then called 'dyslalia'.

Other subjects mentioned less frequently were psychiatry, audiology, counselling, orthodontics and education. This pattern correlates with the curriculum as set out by the RCSLT (see section 4.2). Of note is the biomedical bias of the curriculum and the generally low profile of humanities or social science subjects. Several therapists, including those who qualified in the eighties and nineties, drew attention to the high priority placed on medical subjects as opposed to non-medical areas such as educational policy and counselling. Georgia felt her course in the eighties placed too much emphasis on anatomy. She noted there was still too much focus on this rather than consideration of education issues such as the National Curriculum:

> .....like most courses we did a lot of anatomy and physiology side of things. The job I'm doing now unless I'm missing something it really doesn't apply. I can see obviously if you go into adult work you do need the anatomy and physiology but when you are working with children in a language unit, you don't need anatomy and physiology. Whereas I suppose in my days they didn't have the National Curriculum, but judging from what my student was telling me they get very little on the National Curriculum. For me that seems to be such a burning

> issue these days that if you haven't got anything on the National Curriculum how on earth can you work in a school?

Debra, a graduate in the mid-nineties, regretted missing a counselling course, an optional rather than mandatory subject. Louise commented that her course in the late seventies did incorporate teaching in counselling. However, the students failed to appreciate its importance for rehabilitation. There was a tendency to expect therapy to progress in a linear fashion with the 'cure' being effected as a direct result of the therapist's intervention, as she explained:

> ...we were so bogged down really in the mechanics of speech - the theories of communication and again the course, like all speech therapy courses, they're so intensive. There's just so much crammed into it even though it's four years. We didn't see the - how important the role that counselling has in terms of someone's rehabilitation. We tended to just think you did this, that and the other with them and their speech improved.

Some interviewees observed that the increase in theory had been accompanied by a decrease in practical experience. Sylvia felt students were now 'overloaded' with theory at the expense of the practical aspect. Margo thought this was particularly true of the postgraduate course, having noted the level of support her students now needed:

> *So with the students coming out now, do you think they get less on the practical? Is that how it seems?*
>
> I think so, from the amount of support I've had to give nearly every single student I think that I've had since I came back in the past three or four years. I think they've needed quite a lot of support and I've wondered how some of them have got through. But they have somehow or other. They must be on a very sharp learning curve, really. Well there is with the two-year course, gosh!

However, on closer examination it was evident that people who qualified from the fifties onwards also had mixed experiences as regards placements. The quality of clinical practice appeared fortuitous, depending on the quality of supervision, the breadth and quality of the experience and whether or not theory and practice were taught in tandem. Several therapists attending college in the fifties spoke of problems gaining adequate practice, including Mary whose course was newly-established. An added problem was the lack of clinical supervision:

> We did do some practical but not very much. And I can remember going to one clinic - we had to travel quite a long way - because I went to .....*(educational establishment)* and it

> was only in its second year so things were still very much in the infancy there and mm....I can remember going to one clinic and being - I think we were given some cases of children to see. But I never saw the speech therapist - seriously...

People qualifying thirty years later continued to bemoan the lack of clinical practice. Georgia felt too much emphasis was placed on theory and not enough on practical applications. A major problem was the quantity of practical experience:

> I think it's a problem with a lot of courses - it's this much theory and that much practical and I think the clinical placements aren't long enough.

Ann, a newly-qualified graduate observed that her course focused mainly on the speech sciences rather than 'speech therapy'. The therapeutic element was 'tacked on' in order that students could qualify:

> I definitely got the feeling at the college that I was at that this was a degree in speech sciences as far as the university was concerned and the practical element 'well yes, if you do want to be a speech therapist we'll tack a bit of clinical on so that you can qualify as a speech therapist, but really what we're interested in is a degree in speech sciences'.
>
> *What did they mean by speech sciences rather than speech therapy?*
>
> Well, the whole scientific bit of it - you know - how one produces speech, how you perceive it, what's going on physiologically.

This section highlighted the general trend in speech and language therapy education to increase academic standards. There was a common perception that this strategy was being pursued at the expense of the practical element of the course. This corresponds to some extent with curricular changes which involved the addition of scientific components such as linguistics. However, throughout the period in which the participants trained, the curriculum has been biased towards the sciences, in particular biomedical science. While lack of adequate clinical experience was common to many recent graduates, not all older therapists received adequate clinical teaching.

7.3 The 'scientisation' of knowledge

The above section pointed to the apparent trend of speech and language therapy education to place increasing emphasis on the scientific aspects of human communication. I now examine this perception in more depth, beginning with

respondent's views on the extent to which the course may be defined as 'scientific'. I then move on to explore the way in which the curriculum portrays 'human communication' and consider to what extent this model is a scientific one. Individual subject areas are then examined. The final part of this section looks at the treatment paradigm as taught in speech and language therapy education and compares this with the biomedical approach.

Chapter 6 indicated that speech and language therapy was an attractive career option in that it appeared to combine elements of both arts and sciences. Having been through the course, Debra still felt that the course was a combination:

> I liked the way it was balanced. It was classic that it's humanities and sciences - it's kind of arts and sciences. You don't often get that. You do get the rounded idea.

On the other hand Harriet, who studied speech and language therapy after doing an arts degree, saw the course mainly in terms of its scientific components. She described her arts degree in terms of the creativity required. In contrast, science subjects had a 'right and wrong answer':

> I started off with an arts degree then went on to a science course and I really noticed the difference in the way I had to think and present an essay, for example. Whereas with the arts I could be more creative and have my own argument as long as I could back it up. With science that's not the case. There's more or less a right and a wrong answer with certain subjects.

This was particularly true of anatomy and acoustics where there was no room for argument. She found writing essays in these areas difficult because these subjects were 'black and white'. She remembered thinking, '*You can't have your own opinions here. You have to go by the book*'.

Many interviewees commented on the intensive nature of the course which involved clinical placements as well as full days of lectures. Lynn commented on the general emphasis on fact-learning rather than exploration, particularly in speech pathology lectures:

> It was very much like being back at school, having been at college before going to university. At college we'd had slightly more laid-back lecturers, you turned up if you wanted to, there was more debate and discussion and almost like a seminar approach. When I got to speech

> therapy it was almost like being back at school - it was they were teachers and they were writing on the board and we were scribbling down copious notes.

The emphasis on 'facts' rather than ideas to be explored and debated, came across in the way people talked about the model of human communication portrayed on some of the courses. On Lynn's course, for instance, disorders were presented as facts rather than categories which may be open to question and redefinition.

> ..... it wasn't a lot of debate about anything – 'This is what a language delay is'. End of story. 'And these are the features'. It wasn't 'Well you know do you think that's a true definition?'

The theoretical component of the education also reflected scientific principles in viewing communication along reductionist lines. Lynn observed that the various subject areas were taught separately. She felt integrating these in therapy was problematic since people 'don't come in components'. In her view, the scientific aspect of human communication was a small part of therapy:

> It's not until you go out that you suddenly see a connection between linguistics and phonetics because they're taught very separately unless I was very, very dim. But they're taught in such little components and unfortunately when people come to see you they don't come in components. You have to be able to quickly access your counselling aspects, your psychology aspects - you're dealing with people. And the scientific part is only a small problem-solving thing.

This mechanistic view of communication was further underlined by Louise who pointed out that the course focused on the mechanics of speech. There was a tendency to forget that the job involved working with people:

> It's just essential - you keep forgetting. We did forget that it's people that you're dealing with - not brains and everything else.

There was much discussion around linguistics as it was new to the curriculum in the seventies and had a significant impact on clinical practice. Although language has been studied for 2500 years, the scientific study of language is fairly recent (Cameron 1985).[22] This was reflected in a remark made by Eileen that in the sixties

[22]Scientific linguistics is concerned with objectivity, ahistoricity and the delineation of linguistic systems. Unlike older studies of language it is more interested in explicating the rules underlying language production than analysing sociocultural influences.

'really language was very little understood...'. The science bias of linguistics came over in several accounts. Anna drew a distinction between the everyday use of English and the mechanistic analysis of language undertaken in linguistics. She enjoyed English 'as we use it everyday' but not linguistics which involved 'breaking down' language:

> .....linguistics. I really struggled with that. Having felt that I enjoyed the English language a lot - I really found a lot of that unfathomable.
>
> *Why do you think you liked English language but not linguistics?*
>
> It was probably just a bit too analytical for me. I mean maybe it was just I enjoyed the English language as we use it every day but just found the breaking down of it quite difficult to cope with.

Again, detailed analysis could be difficult to apply clinically. Mike drew attention to the fact that the social aspects of communication were not addressed in structural linguistics. The former was important to communicative competence and thus crucial in clinical practice:

> I was much more keyed into the functional side of communication and what were we all there for - questioning the role of the speech therapist - what's so special about a speech therapist and what were we really there for? And what were we hoping to have an impact upon for that individual? To my mind it was their competence as communicators. So I couldn't really make that jump between looking at clause analysis of *-ed* endings and this kid being able to communicate effectively - being able to make eye contact with somebody - all the social aspects of communication.

Many people stressed the importance of psychology, though several pointed out that academic psychology had limited relevance, or that they were only able to apply their knowledge after several years of clinical experience. The psychology component of Rose's course appeared to be very much along positivist lines. This was not what Rose had expected:

> I had an incorrect idea of what psychology was like. I thought you'd learn all these fascinating facts about how the brain works and everything like that and how people think. Then it turned out to be really boring, mundane lectures about the percentage of people who were depressed and what caused depression and what the symptoms were. And I just thought *Oh.* You know. It all seemed to be numbers and just writing down facts and that was about it really.[23]

[23]This concurs with Wendy Hollway's experience of studying psychology in the sixties. Academic psychology bore no relation to what she expected psychology to be about, as she points out 'I wanted

Anatomy was also described as a subject involving fact-learning and memory. According to Sue, this involved churning out information 'rote-fashion'; the type of knowledge which was easily forgotten if not used.

The evidence indicated that in common with medical education, the course placed considerable emphasis on causation and symptomology. Speech pathology as described by a number of interviewees was concerned with the diagnosis and classification of communication disorders rather than remediation. Liz said that her course had given her the background theory and training in diagnostic assessment. On the other hand, treatment was given relatively little attention:

> You get all the theory and you get the theory even in terms of the pathology and actually identifying and differential diagnosis and all of that and assessments and all of that. Loads of that and loads of the background theory and the psychology and all the anatomy, phonetics and linguistics. All of that, we had it. And the proportion of time that was spent over the entire three years in college on 'This is actually what you do when you've done your assessment'[24].

Further consideration will be given to the relationship between theory and practice in the next section.

In summary, there was some debate as to whether the professional education could be defined as a science or arts course. However, as regards individual subject areas including anatomy, linguistics, psychology and speech pathology, much knowledge was presented as 'fact' rather than ideas open to debate and questioning. Human communication was often presented as an entity describable in terms of the mechanical analogy characteristic of the biomedical approach to the body, an assumption being that the whole can be understood by a rational investigation of the parts. This accords with the approach underpinning much speech and language therapy research as was discussed in Chapter 4.

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to study psychology because I wanted to understand people (that phrase has come to sound trite and naive, but I think it needs to be reclaimed for serious psychology) (Hollway 1989:2).

[24] I think it is fair to assume here that Liz meant she felt there was little time given over to teaching how to remediate disorders after having assessed the patient.

7.4 Theory into practice

Chapter 3 examined ways in which medicine sought professional legitimacy through scientisation. Questions were raised as to whether many medical practices are indeed 'scientific' in the sense of being systematic and based on 'observable' phenomena. Scientisation has thus been used as a professionalisation strategy while its benefits to health care have been mixed. It was seen in Chapter 6 that the people-based aspect of the work was a major reason for choosing speech and language therapy as a career. Given the emphasis of the education on the scientific aspects of human communication, it might be expected that there would be a tension between the theoretical and practical aspects of the course. I now explore ways in which this tension is manifested in the accounts of the research participants.

There was clear evidence from the data of a contrast between systematic teaching in the theoretical research-based elements of speech and language therapy and wide variation in the extent to which people were prepared for the clinical aspects of the work. This appears to reflect a trend amongst the professions in general, as Schön (1983) has argued. By moving into the university sector, the professions have come to emphasise the scientific principles of technical rationality, abstract theorising and ordered knowledge. At the same time lesser importance is placed on the practical applications of the knowledge base. Davies (1995), for example, refers to 'hierarchical practices of knowledge creation' (p.140) in nursing which sustain the theory/practice gap.

While some therapists felt their education was practice-based, others felt ill-equipped for clinical work. Ann, for instance, commented that many of her lecturers were researchers though they had been clinicians in the past. Little emphasis was placed on the applications of theoretical knowledge, with the 'therapy' generally downplayed. Plans to teach therapeutic skills were made but never realised:

> .....they're researchers a lot of them rather than clinicians although I know a lot of our lecturers had been clinicians. I mean the other thing I think is lacking - is the fact that there seems to be so little on how you actually remediate any of the disorders that we came across, you know the actual therapy was really downplayed. And the whole time I was going through

> the course 'well that'll be next term or next month we'll get on to what we actually do in the clinic situation to remediate things'. It never seemed to happen.

Several participants spoke of the depth, detail and level of abstraction of some curricular subjects including the various branches of linguistics such as psycholinguistics, structural linguistics and cognitive neuropsychology. Clare spoke of difficulty with linguistics from the point of view that it was 'airy-fairy' and 'scientific':

> The idea of it I found fascinating. But it was still sort of airy-fairy - I suppose the sort of thing I wasn't terribly used to - that scientific X, Y and Z. Maybe it's just that sort of subject. So although I found that moving on to psycholinguistics quite interesting I still found it quite difficult to cope with.

A number of people commented on the usefulness of linguistics as a tool for analysing a given corpus of language. One of the most enjoyable subjects for Beth was cognitive neuropsychology, a reason being that it had a practical application:

> *What did you like about cog neuro?*
>
> I don't know. It was a relatively simple system for understanding what was going on in my head as well as other people's heads and then the damage that can occur. It was just that thing again of anything that I could actually see that was very specifically related.

However, other therapists perceived a gulf between the use of linguistics as an analytical instrument and as a means of assisting people with language disorders. The emphasis on description rather than 'therapy' was underlined by Ann, who unlike Beth, felt there were limitations to cognitive neuropsychology beyond describing the problem:

> .....the cognitive neuropsychology element which we did in the fourth year which is very complex stuff theoretically, but I could see the logic of it - you know how it would actually explain how different processes are impaired. But I could never understand actually in lectures how I could relate that to therapy. I could see it could explain the condition, but I couldn't see how logically it was going to lead on to actually doing anything about it.

The focus of scientific approaches on classification and description rather than application was further highlighted by Harriet in relation to child language disorders. Other than for learning difficulties, she felt her training was not practical. Compared

with formal teaching on the classification of language disorders, therapy was learnt unsystematically, as Harriet put it - 'picked up' in clinic.

> The training wasn't very practical. The only one I remember being quite practical was .....*(lecturer)* who taught learning difficulties. She was good because she actually gave you therapy ideas which were more relevant when you were in clinic because a lot of the time we were with children we were asked to take a therapy session. At the time it seems important to know that you've got something in front of you, why you're using it and what you're going to do with it. We were really learning about the different types of language disorders which were relevant. But when you've got a child in front of you, you want to know what to do with them and there wasn't a lot of that which was the hardest part. But then the longer you spent in clinic the more you picked up for yourself anyway.

The above account reflected a general view amongst recently qualified therapists that while teaching on the scientific elements of human communication was in-depth and systematic, there was considerable variation in the practical aspects of the education people received. Some participants were keen to stress the practical bias of their courses, particularly those who qualified up until the eighties. Others, particularly those qualifying later, described their clinical experience as down to 'luck', 'a lottery', 'touch and go' or 'hit-and-miss'. Given that the course in latter years has tended to focus on theory, clinical experience was all the more vital, as Liz explained:

> I think we all felt that the vast majority of things we learnt in terms of practical, what you actually do with your patient when they're sitting in front of you was learnt in the clinics and on the block placements. So because of that so much hinged on how good your placements happened to be. So if you were in a naff placement with a lazy therapist then you were sunk really. If you happened to be in a brilliant place with a therapist that gave you enough time and let you have a bit of hands-on, showed you what to do and said 'Oh by the way, come and look at all my background materials' you learnt heaps more. So it's all a bit hit-and-miss.

There were differing views as to what could be expected of the colleges themselves in terms of clinical preparation. Chris, for example, needed considerable support from an experienced clinician on first qualifying. Nevertheless, she still felt there were limitations on the extent to which colleges could prepare students for 'reality':

> I do remember that feeling of 'well, now I'm qualified and so what?' but students still get that after four years - they all say to me in tutorials – 'We realise we are going to be qualified soon and we're just not prepared'. So, I think there is an element of you can never prepare somebody because the reality is always going to be different.

Other therapists did not hold the same view. Susie had considerable difficulty gaining adequate clinical experience, subsequently failing her practical examination. In her opinion, clinical skills could be taught at college, for example, through the use of role play:

> They know how to lecture but they don't know how to teach and they don't know how to train, they don't know how to impart the clinical skills over to somebody. You don't have to go out to a clinic to teach somebody how to do that clinical side.
>
> *How do you teach it if you don't go into a clinic?*
>
> I think you can set up role play situations and you can model it and you can get the question and the answer situation going. And you can listen to the student and find out where the gaps are and you should be able to see all the little steps along the way.

The data suggest that speech and language therapy education has tended to prioritise the teaching of scientific aspects of human communication. Rather less attention has been paid to the practical aspects of the work. The findings also appear to indicate that courses are placing even more emphasis on science. People's accounts revealed that clinical skills, most notably in recent years, were learnt for the most part on clinical placements. However, there was great variation in the quantity and quality of clinical experience people actually received. There were differing views as to the extent to which the theoretical aspects of the course could be used in clinical practice. Nevertheless, it was clear that much theory focused on the assessment of communication disorders, that is on description, classification and diagnosis. A number of people commented on the lack of emphasis on how to 'remediate' problems. While it was apparent that some college lecturers were committed to integrating the practical aspects into theoretical teaching, it appeared that speech and language therapy education in the eighties and nineties had a heavy bias towards science. This would appear to be part of the profession's scientisation strategy. Chapter 4 highlighted the scientific tendency in professional documentation pertaining to research, practice and education. This tendency is also indicated from the perspective of the therapists interviewed for this research.

7.5 Gender, caring and science in speech and language therapy education

A major task of this thesis has been to explore the way in which the activities of scientific endeavour and caring are gendered, with the former generally seen to be the domain of men and the latter, the domain of women. Given these aims, it might be expected that the tensions between the scientific and caring elements of speech and language therapy education would have a gender dimension. It has been shown that the participants were attracted into speech and language therapy because it involved working in close contact with people rather than in a setting requiring emotional distance and concern with abstracted knowledge. Nevertheless, there was much evidence that therapists had broad-ranging interests crossing the arts-science divide, including in the apparently more abstract scientific subjects. This was reflected in their A level choices. However, considerable ambivalences were highlighted around science such as the mismatch between people's perceptions of their ability to do science and their actual performance. I now examine these themes in relation to speech and language therapy education.

It was clear from the interview data that the interviewees' primary concern in undergoing speech and language therapy education was to acquire the necessary skills and knowledge to qualify and practice as therapists. Their main commitment was thus in effect to the applied, therapeutic, lower status aspect of speech and language therapy, generally considered to be the female-gendered element. Ann, who qualified in the mid-nineties, pointed out that though her college was academic, the vast majority of students aimed to become speech and language therapists:

> I think there is something about this particular institution which is highly academic, very theoretical because of the place it is really. But I didn't go just to get a degree, you see. I went for a practical training as well as a degree, where some people might just go for a degree.
>
> *Did that seem to be the case?*
>
> Well it wasn't, actually. The majority did want to be speech therapists. There were a couple who decided they didn't and then they just went for the degree.....

A number of therapists enjoyed the theoretical component of the course because they perceived this to be related to practical applications. Rachel, who qualified in the

seventies explained that in contrast to school, she got a 'buzz' out of studying speech and language therapy because it was related to people:

> I just got a real buzz out of it. Right from the beginning it didn't matter what the disorder was - from the simplest disorder - you know an 's' articulation problem all the way to an autistic child. It was just so varied. But it all still related to that human being, that individual and the relationship of that individual with the rest of society.

Likewise, much value was placed on clinical experience because of its relevance to therapy. Beth highlighted this point:

> It was people-related, it was specific. So what I found great and I still firmly believe in is - I wouldn't sleep from Sunday through to Thursday when my clinic placement was because I was so nervous about it. But every child that I saw I'd then have a lecture and it meant something.

In contrast to the practical applications of knowledge, the speech and language therapy curriculum in the eighties and nineties, as noted previously, consisted largely of subjects which adhered closely to the traditional paradigm of science namely abstracted knowledge, reductionism and quantification. Human communication was typically characterised in mechanistic terms. As was seen earlier, therapists held ambivalent views as to how applicable such knowledge was to therapy. There was a concern to place this knowledge within the context of professional practice.

Furthermore, the theme of female 'competence' in science recurred in that many therapists had negative self-images in relation to the scientific components of the course. All passed examinations in scientific and mathematical subjects including linguistics, anatomy and physiology and statistics, yet many could not reconcile their actual ability with their perceptions. 'Difficulty' with linguistics, mathematics and acoustic phonetics was common, that is, in those subjects which have most markedly 'scientised' the curriculum. Many therapists expressed either a dislike of mathematics or doubt about their mathematical ability. For instance, Harriet remarked that she found statistics hard because her maths was 'dodgy anyway'. Of note was Ann's surprise at doing well in statistics. She enjoyed the subject commenting, '.....got one of my best marks for statistics - in fact surprised myself!'.

Sue's interview underlined a number of tensions in the scientisation of the speech and language therapy curriculum for women with real or imagined difficulty in science and maths. She recalled not liking statistics at all, having failed A level maths at school. Statistics had considerable status on the curriculum which meant that students who failed the subject risked losing their place at college. Sue questioned this policy, remarking that 'good' therapists may fail to qualify on account of their difficulty in this area. Also of note is the fact that 'maths anxiety' discouraged Sue from doing research. As was seen in Chapter 4, much research in the field employs quantitative rather than qualitative methodology. While no other interviewee pointed to a connection between maths anxiety and ambivalence towards research, people's oft-discussed problems with maths may go part way to explaining why women are proportionately less likely than men to be involved in research activity:

> For someone who'd failed her 'A' level maths it was just completely terrifying. I just felt it went much too fast and there seemed to be very little space for people who were really struggling like me and it's what's put me off research ever since really. I feel quite concerned that there are some possible very good therapists out there who aren't now practising because those are the sorts of things they failed and I think 'Well OK yes it is very important but does it matter if you really can't do it. Is somebody going to kick you off the course for it?' And the answer at the moment could be 'Yes'.

The previous section underlined the marginal status of clinical practice on the more recent curricula and paradoxically the significance of this to learning 'therapeutics'. Therapists frequently described the rapid learning process which occurred after they had qualified. Though this might be expected of many occupations which require formal education, it was notable that many of the skills felt to be lacking in speech and language therapy education were the female-gendered aspects of the job. A number of therapists felt poorly equipped to deal with the emotional aspects of the work, drawing attention to the difficulties, for example, in dealing with distressed parents, as Liz explained:

> .....there were lots of things we didn't learn at college which you just have to learn when you start your first job. You have to learn more or less instantly - for example relating to the parents of the child you know where the parents may be very anxious. I don't ever remember anybody telling me how you counsel - probably that's changed now, but we didn't...

Clearly Liz felt counselling was a skill that needed to be taught and not one that necessarily came 'naturally' to therapists. The gendering of 'emotion work' arose in discussion with Mike who recalled a lecturer saying that male students were emotionally immature compared with their female counterparts. They were thus less likely to be able to deal with 'emotional issues' arising in the clinic. This view implies a view that women are 'naturally' more able to cope with people's emotions, contrasting with Liz's view, as above.

> I remember .....*(lecturer)* saying to me at one stage: 'Well of course you'll probably find it more difficult than the girls who have just left school because boys tend to be generally tend to be less mature than girls emotionally and it's going to be quite hard for you because there are going to be a lot of emotional issues thrown up from clinic placements.....'.

There were difficulties for therapists without life experience in coping with the emotional aspects of the job, including loss and bereavement. Again, this questioned the assumption that female students are naturally skilled in managing emotions. Jenny described the difficulty as a newly-qualified therapist in coping with an elderly person who had had a stroke:

> I think I was a school leaver - I was twenty when I left college or I was twenty-one and I thought - I didn't feel very comfortable as a twenty-one year old faced by someone of sixty who'd basically lost everything they had surrounded by their family attempting to do something with them - saying 'There, there. It'll be all right'. It didn't feel right.

Emotional issues arose frequently during therapists' discussions of their work after qualifying. These will be considered in Chapter 10.

Many therapists, in stressing the complexity of clinical work, mentioned the need for on-the-job learning of scientific knowledge as well as people-orientated and administrative skills such as caseload management. Despite the emphasis of the education on science, that is knowledge most closely associated with status and the male professions, many therapists felt their knowledge was inadequate for the job. Chris, for example, had to read up on each disorder:

> I just had to do a tremendous amount of reading in the first year or two years after I was at college. Every patient - I had to read up the disorder.

Similarly, Anna's knowledge of neurology was insufficient for working in hospitals:

> .....at the end of it I just felt that I remembered very superficial things about multiple sclerosis and motor neurone disease and not enough really that was amazingly useful, I don't know. I mean maybe just being remembering enough about it - the diseases - and there being so many more as well. You know you learn about these big things - Parkinson's and strokes. But then as soon as you go into a hospital there are hundreds and thousands of things that you don't know about.

This section indicated that the major factor which motivated students including those who underwent speech and language therapy education in recent years was the female-gendered 'caring' aspect. There was consequently a concern to 'humanise' the theoretical, scientific knowledge taught on courses. 'Scientisation' presented a problem for many therapists in that many expressed difficulty with grasping the most highly 'scientised' subjects. Nevertheless, all had succeeded in passing their qualifying examinations. Negative self-images in relation to science appeared to have implications for therapists' attitudes to male-stereotyped areas of professional work, including research. A number of people felt the education had not equipped them to deal with the relational elements of speech and language therapy. There appeared to be gendered assumptions around the notion of 'emotion work', in particular that it was something in which women excelled and men found problematic. However, there was evidence that many interviewees did not feel 'naturally' skilled in dealing with emotional issues, especially where they had limited life experience. A final point was that the scientific male-gendered elements continued to arise as important once people qualified with several therapists commenting on the gaps in scientific knowledge thrown up in new clinical situations.

7.6 Conclusion

This chapter continued to explore a number of themes already identified in the thesis, including the scientisation of professional knowledge in speech and language therapy and the decreasing emphasis on practical applications. High status subjects on the curriculum were scientific, being concerned with 'facts' rather than debate and a reductionist approach to the study of human communication. While therapists went into speech and language therapy education with the aim of applying their knowledge, clinical teaching occupied a marginal position on the curriculum.

Practical knowledge was by and large gained in clinical settings but therapists' experiences on practical placements varied considerably.

There was a clear concern on the part of therapists to use their knowledge to 'care' for people, that is to carry out the stereotypically female aspect of health care work. On the other hand there were ambivalences around notions of 'science' both in terms of therapists' confidence with scientific knowledge and in terms of their scepticism as to its usefulness in clinical practice. It was argued that therapists' problematic relationship with science in part reflected gender stereotypes about women's abilities in this area. A further assumption as regards gender was the idea that a male student may find 'emotion work' difficult. These assumptions were challenged on a number of grounds: firstly, that the women in the study had all been successful in gaining a 'scientific' degree and secondly that many felt poorly prepared to deal with the emotional aspects of the job. A further point is that though the scientific curriculum was frequently described in terms of its difficulty, therapists generally spoke of embarking on a steep learning curve once they had qualified. This involved honing up on scientific knowledge as well as learning skills necessary to deal with the emotional complexities of the work.

This analysis has shown that speech and language therapy education incorporates both the rational and the relational. It indicates that caution should be exercised in stereotyping these skills as male-female, complex-simple and learnt-intuitive. The next chapter looks in more depth at speech and language therapy practice in the light of gender stereotypes.

Chapter 8

Work: the boundary between the public and private

8.1 Introduction

As noted in Chapter 2, women's work in the public sphere cannot be understood without reference to their work in the private sphere. Chapter 2 highlighted the relationship between women's paid work and their unpaid work in the home and community. It was pointed out that women continue to carry out the large part of unpaid work in the private sphere, including child care and housework. It was also noted that women's career patterns bear a relationship with the level of demands made in the private sphere. This often gives rise to a chequered career pattern which differs from the linear path which is more characteristic of men's careers. A further point was that in order to accommodate their unpaid work in the home, women in the professions tend to spend extended periods at practitioner level rather than move upwards through work hierarchies.

Chapter 8 takes up this theme by looking at therapists' work across the public/private divide. Firstly I consider demands made from the private sphere and the 'juggling act' required to balance paid and unpaid work. I then focus more closely on strategies therapists use to accommodate demands from the private sphere. The next sections consider attitudes to balancing motherhood and paid employment. The final section examines the extent to which family and employers support participants' careers.

8.2 Family care: its demands on therapists' time

It was noted in section 2.2 that women carry out a much larger proportion of unpaid work than men in the home and community. Much of this is connected with the mothering role which most women undertake during their lifetimes.[25] Nawal El

[25]In fact Woollett (1991) points out that motherhood has a mandatory quality and that all women in stable, heterosexual relationships are expected to become mothers.

Saadawi (1997) has argued that society regards this as women's primary role, with activities such as creative work taking second place. A problem for creative women is that

> ....the duties of a wife and mother in serving her children, family and husband still remain sacred in the eyes of society, since they are the duties she has been born to fulfil. Any other activities are considered secondary, or of little importance, or even harmful, since they can divert her from carrying out the tasks related to husband, children and family (p.220).

El Saadawi's observation is borne out by data from the present study which also illustrate the extent to which women take the main responsibility for unpaid labour in the private sphere. Firstly, I will consider the work women performed for their children and secondly, the domestic work carried out for the family as a whole. Twenty-eight therapists, that is the majority of people interviewed, had one or more children. With the exception of one participant, all were living with a male partner, either married or cohabiting. The tradition for mothers to devote their time and energies to raising their children was particularly evident amongst the mature students interviewed. Anna, who had recently qualified, was clear that her ambitions came second to caring for the needs of her children, with everything else being 'fitted in' around that:

> I feel as if I've taken a very, very long time for my education anyway and maybe I would have been more ambitious and done it earlier. I don't know. But I wanted to spend time with my children and so I wasn't prepared to be doing things when they were going to be at school. So everything's always been fitted in with that.

Adrienne, an older therapist who began working as a speech and language therapist in the fifties, commented on the complex juggling act required to organise childcare and continue in paid employment. Her account reflects the trend in earlier decades for women to spend long periods out of paid employment to look after children:

> .....I worked until our first daughter was born in 1963. So I'd worked from '58 to '63. And then I gave up full-time and I carried on at .....*(school)* for two days a week because my mother was able to look after our daughter on those two days. And I carried on doing part-time work until our younger daughter was born and then I gave up completely and was out for about seven years from '68 until '75.

Mothers spoke of a range of activities undertaken to care for the health and well-being of their children, thus substantiating other research on the role women play in 'health-providing' highlighted in Chapter 2. Also in common with other studies, these accounts indicated that the women generally saw themselves as holding the primary responsibility for their children's health and well-being, although this was often due to a lack of alternative childcare. This frequently led to a tension between work demands and family demands. Barbara, a therapist who qualified in the seventies, spoke of being 'torn' between the needs of her patients and the needs of her sick child.

> I have run off wards at seven o'clock in the evening thinking 'Why am I here looking after this patient? Why am I not at home because my own child is ill?' And I think there are times when you're very torn between the two things. The first time I took a locum job the second day of my locum post my daughter got whooping cough. She was off school for seven and a half weeks. I mean we were juggling around with who could look after her. Nobody wanted to look after her because she was infectious. And it was just - and then you think 'Well maybe somebody's trying to tell me something'.

A major demand on mothers' time was being available to take children to and from school, to be at home on their return from school and to care for them during school holidays. Some participants mentioned the need to attend schools for a variety of activities both in connection with their own children and on occasion to 'help out' in schools on a voluntary basis. These activities could clash with work, particularly in organisations which were unsympathetic to parents. Inflexible arrangements such as this meant that one interviewee had to give up work, as Maxine, another seventies graduate, explained:

> I left there and I thought the only way I can be more flexible is to be self-employed. So then my daughter was starting school and I wanted to be able to be more flexible. It was not the sort of establishment where I could have taken off a morning for sports day, for example because kids were booked in from.....*(place)* months ahead.

She noted, however, that attitudes had changed since she left, commenting that the school now had a lot of part-time staff with young families and that they realised '....people aren't prepared to put everything into a job any more'. This is likely to be a reflection of the general trend in women's employment towards part-time working, as was noted in Chapter 2.

For a number of the older women care in the sense of emotional support continued as their children grew up, with many being more concerned for their children's career aspirations than for their own, as Adrienne explained:

> .....my ambitions have been in other directions. I wanted to hopefully raise a well-adjusted family. I wanted to give the children time, I wanted to see them settled in careers that they chose and wanted to do - all of which I must say has happened.

Only one interviewee spoke of sharing childcare with her husband. This was made possible because he worked shifts. Even then this arrangement was described as 'a very highly-strung jigsaw - and if you take a piece out it all falls apart....'. More often fathers played a limited role tempered by the demands of work, as in Maxine's case:

> .....he's always tried to be as supportive as he can. He works in .....*(town)* and he gets back quite late. So he hasn't always been able to - occasionally, very occasionally he's taken time off if I've been totally committed to having to be at something, but not on the whole.

The findings of this study thus indicate that fathers are in general not actively involved in the daily task of caring for children in its widest sense. This concurs with the still-pervasive ideology of the family which carries with it the notion of the father as financial provider.

Data from this study supported other research which has highlighted the extent of women's domestic labour in the home, even with the advent of the so-called 'labour-saving' devices. There were many examples of women working exceptionally long hours relating to both their domestic responsibilities and to the demands of clinical jobs which were difficult to fulfil during normal working hours (see also Liz's account in section 8.3 regarding 'part-time' working and needing to write reports after midnight). A number of people spoke of working in the evenings or at night to catch up with this work, sometimes when the rest of the family had gone to bed. Barbara spoke of the demands of paid and unpaid work. There was strong family pressure for her to assume the responsibility for domestic labour.

> I'm probably washing the floor at midnight as well! Not ideally which is probably why my daughter said to me 'I'll never be a speech therapist'.
>
> *How are your family about that?*

Oh I think they get very fed up with it at times. I think they realise I'm very involved in it. But they do get quite fed up with it at times.

What sort of things do they say?

Well I think my husband'll say 'Don't tell me you're going back to the hospital this evening again or you're not going to...'..I think they're fed up with having the piles of things around the house....

8.3 Patterns of paid employment: part-time working and the non-linear career

This section looks at therapists' patterns of paid employment in the light of women's labour market activity in general. The issues considered are part-time working, patterns of withdrawal and re-entry from and to the labour market and the need for flexibility. These patterns will then be examined in comparison with the 'normal career' (see Chapter 2).

As was noted in Chapter 2, a significant feature of women's paid employment is that of part-time working, with 42% of all women employed in this capacity. Of the 33 people who stated whether they worked full or part-time, 14 worked part-time, a figure which concurs with the national figure. As regards family situation, it was notable that all the part-timers had children and that those without children, regardless of marital status, worked full-time. Analysis of participants' present jobs according to whether they were full or part-time revealed that though a similar proportion of part-timers were leaders of clinical teams, considerably fewer were managers of speech and language therapy services (Table 8.1). Of the 33 therapists who stated whether they worked part or full-time, only one managed a Trust-wide service on a part-time basis.

Table 8.1 *Type of job by full or part-time status**

	Full-time	Part-time
Manager of SLT service	3 (16%)	1 (7%)
Leader of clinical team	7 (37%)	5 (36%)
Clinician	9 (47%)	8 (57%)
Total	*19*	*14*

Thus it can be seen that part-timers are concentrated in the lower grade jobs rather than in higher-paid managerial posts. This concurs with Mays and Pope's (1997) research which found that the vast majority of speech and language therapy managers - 89.8%, work full-time. It also reflects the tendency for women with professional careers to remain in practitioner roles during periods of part-time employment.

Pascall has observed that women's withdrawal from the labour market to have children is often followed by a 'chequered pattern of part-time work, reduction in status and earnings combining paid and unpaid work roles' (Pascall 1994:18). The pattern of a 'chequered' relationship with the labour market was true of many of the married women interviewed. Liz, who graduated in the eighties, described how she worked full-time until the birth of her first child. This was followed by a period of sessional work until her second child was born when she gave up work completely. She then returned to a series of locum posts:

> .....there was one session that was free - they'd filled those sessions but there were two or three particularly difficult mainstream schools and nurseries. So I did this one session a week which just kept my hand in a bit I suppose which was quite nice. I did that for two years until I fell pregnant with my second child when I then resigned. I wasn't entitled to any maternity leave after one session a week anyway. And I left for a year - ten months to be exact. After ten months a locum post came up - an adult post and it was supposed to be for four weeks or something like that. It was four or five sessions a week and I was asked if I could just help out. So I said yes and when that period had finished another locum post came up in a different hospital with adults, so I said yes to that.

The difficulty of combining work and family roles in a management position was highlighted in the research. Part-time positions at managerial level were scarce. Where these did exist they were vulnerable during times of organisational change, as Clare, a mother and a manager of a large service explained:

> I work four days a week - I don't work full-time and I am not prepared to do that. I feel quite strongly at this point in time I can't do that. So it depends on the flexibility of those management roles.

This would tend to reinforce the notion that part-time work is not considered relevant to the 'linear' organisational career, thus disadvantaging women's career paths (Crompton and Sanderson 1990). It thus appears that segregation between full and part-time workers in terms of grading and access to well-paid posts, characteristic of women's work in general, is a feature of the speech and language therapy workforce.

Part-timers frequently complained of not being able to complete administrative tasks such as report-writing in work hours, needing to bring this home and fit it around domestic commitments. Again, this could mean working exceptionally long hours, as Liz described:

> .....I might do it at ridiculous times - I'll do it when everybody's in bed and by that time - everybody including my husband. I'll be writing reports at two o'clock in the morning because it's the first time all day I've had to sit down and do it which is ridiculous.

Chapter 2 highlighted the importance of analysing women's position in the labour market in relation to their family responsibilities. The examples above underline the significance of this relationship. Clearly, children were a major reason for withdrawing from the labour market and re-entering under different conditions, in particular by working part-time hours. However, motherhood was not the only aspect of family relations which influenced women's employment patterns. Another influence was that of partners' careers, husbands' job moves often taking precedence

over wives'.[26] Mary, who completed her professional education in the fifties, travelled extensively with her husband's work. She felt this was a major factor which had held back her career. However, there was a sense in which she found this acceptable. At one point she passed up the opportunity for promotion due to an imminent move with her husband's job, commenting that to have applied for it would not have been 'fair':

> *In terms of your career in speech therapy do you think there are certain aspects which have held you back in your career development? You mentioned the lack of learning opportunities you had in the beginning. Are there any other things?*
>
> Yes, the fact that my husband's had to move around for his job. Because when we were in .....*(town)* I would have become District Therapist there - I say I would have done that sounds terribly arrogant - I might not have been, but I would have applied for the post and probably stood a good chance of getting it. But it was the year - that was the middle of the year - April, May that I knew we were moving in August, so I mean I didn't apply for it - would have been pointless and not fair either.

In spite of the fact that few part-timers were in well-paid positions and the difficulty they had in keeping to their contracted hours, many women saw flexibility including part-time hours, private work and term-time working as an advantageous aspect of speech and language therapy. Implicit within discussions around flexibility was again the notion that women took primary responsibility for the family. A number of people expressed the idea that speech and language therapy, like other jobs involving children, was particularly suited to women because they were easier to combine with caring for a family, as Barbara pointed out:

> .....we're very lucky as speech therapists that it is possible to get part-time work and combine it much more easily than you can many other professions. I think that's a good thing about it and naturally if you're working in education you even get school holidays. You don't in hospital but you do in education and that's a very big plus point for many people.

Nevertheless, NHS work was not always thought to offer sufficient flexibility especially with very small children. Private work was felt by some therapists to be more adaptable to the demands of motherhood. Caroline who trained in the seventies

[26]Delphy and Leonard (1992) note that wives almost always follow their husbands' careers even when they themselves have prestigious jobs. This puts women at a disadvantage in that they may not choose the location, it may take time to find another job and support structures may be limited.

had worked for the NHS and in a private capacity. She found the latter more flexible when her children were small.

> .....before I went back to work for the NHS I was seeing patients every day. I'd probably see - when I had babies I'd see them when the baby was having a sleep and when they got older it seemed to fit in quite nicely.

This section has shown how patterns of women's paid employment are tempered by domestic responsibilities, placing them in a disadvantaged position as regards the 'linear' career which involves unbroken service and steady upwards promotion. Sue, who gained her qualification in the eighties and had achieved a promoted post on a part-time basis, felt it was important for therapists to achieve seniority prior to having a family:

> I think I'm lucky because I got pregnant when I was already quite senior. A number of colleagues who are a similar age to me got pregnant earlier and came back and still haven't got to my level of seniority. But getting the clinical expertise label and then going away and having the career break means you can come back at that level. If you do it in reverse you can't seem to build up part-time into any sort of decent job which I think is a problem that needs addressing.

Again, this raises the point that women with children risk losing out on well-paid employment reinforcing the part-time/full-time divide in the labour market. This has major consequences for the female-dominated professions, for as Davies (1995) points out in relation to nursing, home and family commitments take priority at particular times during the life-course so that interests in promotion, willingness to move and to relocate families are different for men and women. Inherent within the domestic responsibilities argument is the assumption that it is women who should forego employment opportunities. It was clear, however, that many interviewees did not accept this unproblematically, as will be seen in the next section.

8.4 Discourses of motherhood: attitudes to paid employment

This section explores study participants' views of motherhood and considers how these views reflect competing discourses around the role of the mother. I then examine the effect these have on people's attitudes towards their careers.

The women held a range of views on parenting as the mother's responsibility, including amongst the generation of women in their forties and fifties. Some accepted unproblematically the idea that only the biological mother could raise her children adequately. Implicated in this view was the notion that women should choose between motherhood and career, even when attitudes appeared to be changing. Karen, a therapist who began working as a speech and language therapist in the seventies, did not feel a career should be seen as important:

> .....things have changed and that you should think about your career and that's important. I don't see that. To me why bother to have a child if you're only going to see them from six to eight. I just don't really understand them - you're handing over the bringing up and the instilling values and all the rest of your child to one other person or a succession of other people.[27]

Other women had returned to work, sometimes in a full-time capacity, superficially appearing to have come to terms with the work/motherhood dilemma. Even so, their accounts suggested that they still saw their responsibilities lying in this direction, with childcare placing a major strain on one's time. As Marion pointed out:

> You have to be, if you were organised before you have to be mega-organised because you've got a whole chunk of your personal time is taken out looking after children, organising it....

Margo qualified around the same time as Karen but held very different views about childcare. She became pregnant shortly after qualifying and wanted to carry on working, much to the consternation of her health visitor:

> I remember I was looking for a childminder at the time and I had stupid comments from my health visitor like 'If you're looking for a little hobby' I think somebody said once, 'Why don't you ask your husband to hold the fort while you can go out and do a little hobby. You can't leave your child until they're emotionally independent of you'. And I said 'That could be in twenty years' time. What are you saying'? A child is always to an extent emotionally dependent on their parents, very often until they die in some sort of intangible way.

Margo's annoyance was fuelled by ideas from the feminist movement of the seventies:

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[27]Phoenix and Woollett (1991) indicate that the instilling of values, as described above, is part of the politics of motherhood. Mothers are generally expected to reproduce the culture by engendering the appropriate values in their children, thus developing them into 'responsible and mature citizens' (p.17). See also Rich (1979) for further discussion of motherhood as an institution.

> .....that was still very prevalent - that you did look after your children or stay back. It certainly was with this group of health visitors. I remember feeling extremely annoyed about it. And it was the feminist movement time as well, early seventies.

The data reflected changes in social policy with regard to employment protection rights such as maternity leave and the increasing trend for women to return to work soon after the birth of their child. In the late sixties and early seventies employers who kept jobs open for pregnant women were seen as innovative. Many employers, however, gave no maternity rights, forcing women to give up their jobs. Vicky, who completed her speech and language therapy education in the sixties, retained part of her job because of a sympathetic employer:

> You just gave up. 'Why were you working anyway?'[28] Partly. So I had to leave .....*(hospital)*. But fortunately the other bit of the job was .....*(education)* and they were always very forward looking employers in that kind of way and they said 'Let us know when you want to come back'. They just put somebody in the meanwhile and they did that for both my pregnancies which was extraordinary for those days because it was unheard of.

8.5 Attitudes to careers: challenging stereotypes

In this section I explore therapists' attitudes to their careers. I then consider material constraints to careers, developing the theme of family demands and secondly on-the-job constraints which may act as disincentives to seeking career development.

Despite the dominant model of career involving continuous service and upward mobility which is generally incompatible with raising a family, many therapists displayed strong commitment to their careers. This contradicts the stereotypical view that mothers lack occupational drive and ambition (see Chapter 2). For some participants, career development involved upward movement through the management hierarchy, characterised by a strategic approach which is said to be more commonly associated with men.[29] Other people were more keen to develop their clinical skills by gaining formal qualifications such as advanced diplomas,

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[28] I suggest here that Vicky was speaking for colleagues who questioned why it was necessary for her to work.

[29]Hardy (1986, quoted in Davies 1995) found that female nurses made a series of sideways moves at the beginning of their careers, gaining qualifications but remaining at the same hierarchical level. Those reaching sister level often returned to work as staff nurses after taking further qualifications.

Masters or doctoral degrees or by attending courses on clinical issues. Louise, a therapist and mother who qualified in the seventies, was keen for career development:

> I think it's perhaps my own personality and attitude. I've always been the sort of person who just doesn't let the grass grow under my feet. If I think I want something I'll go for it. That sounds as if I'm competent. I'm not. It's just that I think 'Oh well. Let's go for this'.

Given the evidence that women in male-dominated fields tend to occupy practitioner roles and stereotypical notions of women's lack of ambition, it might be expected that women would have negative attitudes towards the managerial aspects of speech and language therapy. For Clare and Marion, both mothers, this was clearly not the case. Participation in management afforded Clare the opportunity to take on the long-term planning of a service. This was something she relished in contrast to previous managers who had not taken on this role:

> They wanted to work with the patients. They didn't want to do anything else. The opportunity was there and I took that on board. And immediately I loved it. It was in the days when things were moving very much more slowly and I think the first thing my boss gave me to do was to do the five-year plan for the service. I didn't find it that daunting. I thought 'This is great! It's an opportunity to sit down and work out where we're going for the next five years'.

Other therapists, including 'high-fliers' in career terms, had not actively planned their careers, including Marion who felt that getting a management post was due to being 'in the right place at the right time':

> .....a lot of people do plan their careers. They will be saying 'Well I've done three years in this, then I should be looking for that and for that and then by the time I am X I want to be this, I want to be a Chief Executive, I want to be a.....'.and I don't think I've ever done that, really.
>
> *But obviously you've had the skills to.....it can't be just luck you know!*
>
> No. Presumably one hopes I was competent to do it, but it was circumstantial, really I think - that those jobs happened to be there at the time.....

On the other hand, lack of confidence was a major problem for a number of therapists, particularly those who had returned to work after a career break to have

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Men, on the other hand, took fewer qualifications and moved quickly into senior nursing posts via

children. Loss of skills could be a significant factor leading to poor confidence.[30] This was very much the case for Rachel who prior to having children had enjoyed a high profile career. On returning to work she felt unable to meet the expectations which were placed on her:

> ...there is an expectation. *I* didn't feel that I could meet that expectation because having been out of the profession my confidence had dropped. Now I can meet it again, but that's after four years of being back.

Whatever people's attitudes towards their careers, these were circumscribed by personal situations, most notably childcare responsibilities. The commitment of time could be a major problem for people thinking of pursuing a further qualification. Lack of promotion opportunities afterwards could be a further disincentive, as Rosemary, an eighties graduate with two young children pointed out:

> I know it's a very negative viewpoint, but I do go through phases of feeling very negative about the whole thing. I think well if I'm working my guts out for this and it gives me no more financial reward for busting a gut to try and get this ASC[31] which I know is a very unprofessional thing to say.

Louise felt a management qualification would be necessary to further her career, but did not see herself as sufficiently 'smart' to balance this with the needs of her family:

> .....if I was going to do something like that I'd probably want to access some sort of formal management type of qualification. I don't think I could go any further with the work without that. So that's something that I feel perhaps I should have done a while ago. But I couldn't - I can't - having children as well as this job - I couldn't do it. Some people can. But I'm just not that smart.

Research appealed to Barbara, but again her options were limited because of domestic commitments:

> I think it would just depend where they were at. I mean I have a daughter who's only got another year and a half at school and she will then be leaving and hopefully going on to university but a son equally who's got another four and a half, five years ahead of him still.

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charge nurse positions.

[30]Rees (1992) notes that this is a significant factor in women's acceptance of demotion on return to work and of part-time rather than full-time work.

[31]Advanced Studies Course - specialist clinical courses accredited by the RCSLT including aphasia and SLT with Deaf people.

A further material factor touched on in Rosemary's interview was that of pay and career structure. A major problem for therapists interested in clinical development was the 'ceiling' encountered once a certain 'spine point' had been reached. The only other option for Rosemary was to go into management:

> .....it's generic management now I've gone as high as I can as a speech and language therapist in my district and I'm on spine point 31 and that's it. That's as high as the specialisms go.
>
> *So you couldn't move up unless you went to be a generic manager, basically.*
>
> Yes, yes. [32]

The career structure is likely to alter as a result of the Equal Pay case, but no change has so far come into effect. Coupled with dissatisfaction over the career structure was a general view that in comparison with other graduate professions speech and language therapy was poorly paid. This again connected to the traditional gender ideology of the male breadwinner/female housewife with speech therapy wages perceived in some quarters as a secondary wage or 'pin-money'. For many women in dual-earner households this reflected reality, it was not so for other therapists. The main income for a significant number of people who took part in the study was from working as a speech and language therapist. Of interest was the way in which the research participants tried to account for the salary structure. Liz suggested that speech and language therapy, like nursing, was still seen as a vocation, a job done for love, not for money. This carried with it notions of dedication and selflessness:

> .....there was something on the radio this morning funnily enough. They were comparing what people earn at the top and what people earn at the bottom - the top earners who earn literally millions of pounds a year. And the person who was speaking on the radio said 'And a nurse earns £15,000 tops' or whatever it was. Dreadful. Because everybody thinks 'Nurses. What a wonderful job'.

Such a concept brings with it the danger that work considered to be a woman's vocation will not be properly remunerated. As Liz pointed out:

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[32]There has long been concern over the inadequate career structure in the profession, in particular the lack of a pathway for clinical specialists (Bebbington 1995). Davies (1995) notes a similar situation in nursing. Promotion above sister level means moving into management or education, with no equivalent clinical pathway.

> ....because it's a vocation they're allowed to get away with it. It's all right. You can get away with paying these people less money because they enjoy what they do so much because that's all they ever want to do.

It has been argued that the notion of vocation is 'gendered' in the sense that the female professions are equated with skills considered to be innately 'feminine' rather than with skills acquired through training and formal qualifications. Salvage (1985) has argued that the low earnings of nurses are related to the fact that nursing is perceived to be 'women's work' with nursing seen as an extension of women's work in the home.

8.6 Support for careers: variability in the home and at work

This chapter has shown that though many therapists aspired to develop professionally, their ambitions were tempered by domestic commitments and lack of career incentives. Bearing these findings in mind, this section examines other people's attitudes including those of family and employers towards participants' unpaid and paid work.

As regards unpaid labour, it will be recalled that Barbara's family expected her to take responsibility for the housework. Many women did not directly comment on the lack of help from their husbands, or if they did, the demands of paid work were frequently given as justification for this. In terms of childcare, female relatives were often relied on for support as Sarah, who qualified in the eighties, explained:

> My husband's got quite a busy job. I can't always rely on him - I've got a sister who lives near .....*(hospital)* so if there's any crisis in child care I've usually got her to jump on. But yes, I think the other thing about women is that you don't often have the support networks near to home. I mean I don't have a mother that lives nearby or a mother-in-law or really any other family that can leap in and do things.....

In terms of employers' attitudes towards demands made on women from the private sphere, one might expect there to be more sympathetic attitudes amongst speech and language therapy managers, given that most are women. There were mixed experiences in this regard. Liz, for instance, felt that a major factor which had

facilitated her career was a manager who was understanding of her need for flexibility:

> I think that's the single biggest plus that I've had is a sympathetic manager who's extremely tolerant of my demands really. She's often come to me. Three of the jobs she's offered me, although I've been interviewed for the jobs and I think in every case there were other applicants, in every case she's actually phoned me up and said 'There's this job going. Are you interested? I think you could do it'.

Other managers, including female bosses, were not as flexible, as Rachel pointed out:

> ....you find that a lot of speech therapy managers even female managers are very unsympathetic towards the kind of timetable you need to run - and I find that - to be honest with you - totally unacceptable.

This again placed mothers at a disadvantage compared to male colleagues, or female colleagues without children. Rachel felt that progress in a profession with a career structure was predicated on the 'freedom and opportunity to rise to the top'. This necessarily excluded women with family responsibilities. Negative attitudes were not, however, confined to managers. Negativity towards part-timers could be encountered from colleagues lower down the hierarchy. Sarah had good support from her boss to work part-time as manager of a team. However, her therapists were not so supportive:

> .....although I work part-time, my managers are very supportive. Not every therapist is supportive of that. I mean I know that's coming from the bottom up. A lot of resentment that I've had to deal with about 'She's a principal and she's only part-time, you know'.

This experience resonates with research described in Chapter 2 which highlighted the continuing influence of dominant ideological constructions of motherhood, whereby women returning to work could experience hostility from work colleagues as well as relatives and friends.

It was noted in 8.2 that along with the increasing trend towards part-time working, organisations were now more prepared to employ therapists on this basis. However, in terms of childcare provision, there were still major inadequacies both within the public and charitable sectors. It has already been noted that many mothers relied on family care as well as private arrangements. Employer-organised childcare was not mentioned by any of the participants in this study other than to point out that it was

woefully inadequate. Sue, for instance, commented jokingly that the usual arrangement in the NHS was 'one nursery for an entire community health area'.

Turning to people's attitudes towards therapists' paid employment, there was evidence of support from male partners towards their female partners' careers. Marion did not feel marriage was a barrier to her career because her husband had supported her in whatever she wanted to do and she had done likewise.

> I don't think marriage affected my career at all because, you know, my husband's very supportive of my career as I am of his and so between us we encourage each other to do whatever.

However, it was more common for female interviewees to describe male partners as unsupportive or disinterested in their work. Christine, who began her career in the seventies, felt successful women were a problem for men. The level of support men gave depended on the extent to which they had achieved their own career goals:

> It all depends, again, on whether they're successful in their own field and whether that gives them enough security, actually. But it is a problem, of course it is. Successful women are a real problem! *I* think. Men have a real problem in dealing with it!

Lack of support could sometimes be limited through lack of interest in speech and language therapy, as Maxine explained:

> My husband comes back last night 'What sort of day have you had?' '.....'s tube's come out!' He works in .....*(occupation)* so he's involved with people and he has to deal with people all the time, so if I've got any videos with kids with eating problems he doesn't want to look, he doesn't want to know anything like that.

It may be that younger partners, such as Marion's, are more supportive as a result of women's changing relationship to the labour market. Several older therapists spoke of strong, negative feelings amongst family members towards their jobs. The husband of Sylvia, who completed her course in the fifties, was particularly deprecating:

> .....he was always angry about me being in a job where I wasn't fulfilling my potential but when it actually - when I did get out of it and try and do things he gave me very little support. So he was very crippled by society in the way that I was too. You know he paid lip-service about my being in a job that had no credibility.

An extreme example was Margo's father who could not remember his daughter's occupation:

> ....I don't know what he thought of speech therapy. For a long time he couldn't remember whether I was an occupational therapist, a physiotherapist or a speech therapist.

8.7 Conclusion

Data presented in this chapter tend to support the view that women's work in the public sphere cannot be understood without reference to their unpaid work in the private sphere. Women took on the main responsibility for work in the home including childcare and domestic labour. Social expectations and social policy reinforced these roles, though it was noted that changes are afoot with the government currently increasing funds for childcare provision. The employment pattern of many women was clearly influenced by the demands of the home so that they were frequently unable to conform to the 'normal' model of career. A number of strategies were used to cope with this including working part-time, becoming self-employed, doing locum work and taking 'work' home in the evenings. Many people also remained in 'hands-on' roles. A marked change appeared to be the fact that many women were less likely to spend long periods out of paid employment, a development which paralleled legislative changes regarding maternity rights. Advancement in terms of gaining further qualifications or entering management was problematic.

The persistence of patriarchal ideology regarding a 'woman's proper place' was still very much in evidence. However, many women subverted feminine stereotypes of a lack of commitment to paid employment, showing a high degree of initiative and interest in their career development. Support for this was variable with some partners, managers and colleagues influenced by dominant views. Others, however, gave high levels of support. In many cases this was the crucial spur to achievement. Aside from social expectations, pay and career structure were major issues constraining career development, lending further support to the critique of the 'domestic responsibilities model'. Poor pay in speech and language therapy was

thought to be connected with the notion of vocation, caring work considered suitable to women's 'innate' capacities and therefore not worthy of adequate remuneration.

Chapter 9

The status of speech and language therapy as a health care occupation

9.1 Introduction

Chapters 6 and 8 have shown that traditional gender ideology continues to have a marked influence on women's career paths, both in terms of their career 'choices' and their subsequent work experiences. Chapter 7 showed that the professional education of speech and language therapists focuses on the scientific rather humanistic aspects of human communication. The thesis has also pointed to a contradiction between the nature of the education - highly scientific and one would expect, high status, and the status of speech and language therapy which is relatively low.

This chapter examines the subordinate position of speech and language therapy as a paid form of health care work and the relationship of this to gender. It first examines outside perceptions of the nature of speech and language therapy and then looks at therapists' conditions of work. The next section considers relations within the health care system focusing on the profession's relationship to medicine, while the final section considers gender as an explanatory factor in the marginalisation of speech and language therapy.

9.2 Outsiders' views of the profession as perceived by the study participants

I indicated in Chapter 5 that every therapist I approached agreed to be interviewed. There appeared to be unanimous concern about the low profile of speech and language therapy. Indeed, the leader comment in *Bulletin* in February 2000 refers to 'our little-known profession' (p.3, Sheridan 2000).

This section shows that therapists perceive that outsiders view speech and language therapy as limited in scope and that it requires little training. They also perceive the work as being 'invisible' when compared to other health occupations including clinical psychology.

Many participants noted the persistence of the idea that speech and language therapy was concerned with speech production, involving elocution or correcting people's accents. Other professionals such as teachers were well-informed regarding therapists' role, but others still regarded speech and language therapists as concerned primarily with speech. Debra, who been qualified a few years, gave input to two schools and had established a good rapport with one of them. In the other school the teachers' views of the speech and language therapist's role differed from hers:

> .....the teachers don't listen. They've got their own ideas and you're just in there to make people speak better, speak proper, speak a bit more clearly and they cannot see the communicative side.

According to Harriet, the elocutionist image was generally alive and well. The name change from 'speech therapist' to 'speech and language therapist' represented an improvement[33], but there was still a long way to go:

> ....so it's a lack of understanding about what speech and language therapy's about. I must admit that for me too is a bugbear because the number of people that assume that you're an elocutionist - and that's still happening. Unfortunately the old style speech therapy is still sort of misting people's view of what we do now. We refer to a speech therapist and as far as I'm concerned I'm not a speech therapist, I'm a speech and *language* therapist or even better would be if I could say I was a communication therapist.

Even within statutory services, awareness of the scope of speech and language therapy could be limited. A number of people commented that medical aspects of the work had a higher profile than input to social services and education. Clare pointed out that speech and language therapy was difficult to 'market' because of the difficulty other agencies had in grasping the full range of the work:

> .....when I try to do the marketing point of view it appears to be the confusion over – 'Well who is it you work for?' It's still the fact that we're straddling all these different areas. Are we

[33]The name *speech and language therapist* was adopted in 1991 following a ballot of RCSLT members. Until then the RCSLT was called the College of Speech Therapists.

> working in education? Do we work for social services? Health? What have special schools got to do with that? It appears to be that profile that is so confusing for people.

Regarding the extent to which the recognition of speech and language therapy had changed, there were positive comments. Maxine remarked that as a student she used to get 'all the how-now-brown-cow jokes'. Now people had a much better idea of what the job involved.

The consensus of opinion was, however, that the lack of appreciation of speech and language therapy persisted. Lynn pointed out that this was a fundamental problem in the fifties and was still with the profession even now:

> .....we found one of the very first speech therapy Bulletins - it was called something else then and there was an article about 'The role of the speech therapist. Why is she misunderstood?' And that was fifty years ago. When we have our Golden Jubilee we'll still be writing these articles. It was still fundamentally an issue fifty years ago. That would have been probably late-fifties that one. It was so funny to be all those years on and nothing had changed.

Linked with the idea that speech and language therapy was concerned with the cosmetic aspects of communication was the perception that it involved little training as was highlighted in Chapter 1. According to Jeanette, people were surprised when they were told it took four years to qualify as a speech and language therapist. By contrast, people were more aware of the time it took to become a psychologist. This related to the latter's higher profile in the media:

> You know people say 'God - four years to train to be a speech therapist? What do you do for four years?' But no-one would say that to a psychologist.
>
> *Why's that do you think?*
>
> Well because people see psychologists on the television - Doctor So-and-so, clinical psychologist, waffling on about some case or other from eating disorders to who killed So-and-so - where might this murderer be? And they have a very wide profession. They get much more press on all the areas they deal with. When have you last seen a speech therapist talking about a court case for a communication-impaired person or you know anything like that?

There was a consensus of opinion that the 'profile' of the profession was still problematic in spite of research which highlighted this as an issue over 25 years ago (see 2.7), although some participants thought there had been an improvement. Margo felt that speech and language therapy had a very low profile in the media and there was a poor 'general understanding of what it's about'. She pointed out that the

profession was still constantly looking at ways to promote itself. Vicky also felt people's understanding was limited and that there needed to be more media coverage to get across the scope of the work:

> Even when we do get publicity in the press it's maybe mentioned in connection with a new unit for the deaf or somebody who's had a stroke. But it doesn't tell people. People still have this very basic idea. What we need is a TV series. A whole TV series in prime viewing time.[34]

On the other hand Mary thought that during her long career in the profession it was 'very well thought of now generally from the public'. Pat, who qualified in the sixties, noted that the profile had improved in acute settings but that there was still a problem with GPs:

> At one stage I think that related to hospital work because that was the main focus whereas it had a reasonably high profile in schools and education. I think we improved that and often in hospitals often it has a much higher profile. I think the big issue now is with GPs where I think speech therapy has a comparatively low profile. I think part of that is related to the difficulty of access to GPs by all other professions not just speech therapy.

This section has indicated that these therapists are concerned about the poor awareness of the scope of the work and the length of training on the part of both the public and some professionals. By contrast, clinical psychology was seen to enjoy better public recognition in terms of appreciation of the education required and its higher media profile.

9.3 Marginality and the struggle to improve conditions

This section highlights the marginality of speech and language therapy in relation to the profession's difficulty securing an adequate career structure and working conditions. I also draw attention to the struggles therapists have undertaken to improve the situation.

Recognition of the scope of speech and language therapy was important as regards the career structure. Where understanding was limited there was greater risk of losing what career structure there already was. Marion explained that contrary to popular

[34]Public relations were a major focus of the College of Speech Therapists in the early nineties. One of the priorities was to promote the production of TV documentaries on people with communication impairments and the work of speech-language therapists (College of Speech Therapists 1991).

belief the occupation was not hierarchical compared with other services such as nursing. It was therefore difficult to 'rationalise' in times of reorganisation:

> I think there's a belief sometimes, that our structure is very hierarchical because nursing is very hierarchical and in fact I think our structures are very flat.....there's not a lot to chop out and sometimes I think they think you don't do anything!

Marion's comments reflected widespread dissatisfaction with the career structure in the NHS and the sense that it was vulnerable during service restructuring. This had improved with the creation of Area Health Authorities and later District Health Authorities, but was now being dismantled with the reorganisation of the NHS into hospital Trusts. A number of older interviewees described how the career structure had developed, with therapists initially accountable to medical doctors. Later this changed with services uniting under a speech and language therapist in each Area Health Authority. Areas were then broken up into Districts in the eighties and District posts established. More changes accompanied the introduction of NHS Trusts with some units removing speech and language therapists and replacing these with generic managers,[35] as Caroline described:

> Not so long ago we had the Area Therapist and then we had someone in charge of the school service, someone in charge of the paediatric services and someone in charge of the adult service and then we had specialists below that. There was a real structure that had been really got from sweat and blood over the years. And you really notice that having stayed in one area having stayed in one area for quite a long time. Then the trusts come in and things disappear and the District Therapist went and now management posts - people in charge of us are not speech and language therapists any more.

Chapter 2 drew attention to poor working conditions as a significant problem for the profession as highlighted by the Quirk Committee in the seventies. I now wish to examine respondents' views on this, focusing on the extent to which working conditions have changed over the years and the significance of this for the position of speech and language therapy in health care services. Two issues are considered - level of support from colleagues and the provision of resources such as accommodation and equipment.

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[35]In fact research by Mays and Pope (1997) indicates that the majority of speech and language therapists are still directly managed by speech and language therapists, not by general managers.

A number of older therapists, particularly those working in hospital settings, enjoyed good support from experienced therapists from whom they were able to learn whilst newly-qualified. Pat spoke of working with a colleague regarded as one of the 'doyens of speech therapy'. Similarly, Paula had good support in her first post:

> I was part of a group. So it was different but the training you had really did seem to equip you well and the support that you got from your colleagues - there were five of us - you know it was good.

This experience was not, however, common to many therapists, most notably those working in the community. According to the RCSLT (1995) most therapists in the forties, fifties and sixties worked in isolation with no supervision and were chiefly accountable to a clinical medical officer or consultant. A number of therapists spoke of never seeing another speech and language therapist and being accountable to a medical doctor, as Vicky described:

> I think my manager was a health centre doctor. I don't think there was any hierarchy at all. There wasn't anybody else I don't think. I really don't think there was.
>
> *So you never saw a speech therapist from one week to the next?*
>
> No, no. You didn't expect to.

Mary also spoke of working in isolation for much of her early working life, linking up with a colleague much later on in her career.

> I can't remember seeing very many children - it's a long time ago but I know I never had any contact with anyone whatsoever - not even teachers - because I don't think there was even a telephone in some of the places where I worked that was available for me, anyway.

Despite improvements in staffing levels and changes in the career structure in the seventies and eighties, people's experiences continued to be mixed with regard to the degree of contact they had with other staff and the level of support they received. People still described isolating situations, even including in hospital settings. Chris recounted her experiences in the late seventies:

> I took a job when I was first-qualified as a single-handed speech therapist and nobody had ever worked with the adult population before. It was pretty tough. I was 21, newly-qualified. I went

> to work in .....*(place)*, in an area that had a speech therapist for paediatrics for 20 years but never had a speech therapist for an adult service at all.

As discussed in Chapter 2, much emphasis is now being placed on the need for supervision for both newly-qualified and experienced staff. Overall, fewer therapists appeared to be working in isolation over long periods of time. Some people described well-structured supervision with a senior member of staff. Sue talked about a scheme which had been introduced in her Trust. At first she was sceptical, realising its benefits only after a period of time:

> Again my previous job in .....*(Health Authority)* those sort of mechanisms were there but they were very understated - there was nothing official. When I first went to .....*(Health Authority)* I thought 'This sounds terribly sort of American - lie on the couch'. And I went along thinking 'Grief. Do I really want to be here?' But I couldn't place a high enough value on it now having experienced it.

It was clear that many therapists were attached to departments or clinics where they had frequent contact with colleagues. This was especially important for newly-qualified therapists for whom access to advice was important. Nevertheless, several people who had qualified recently conveyed a sense of isolation in describing their first posts, including Debra who worked part of her time in a hospital. Meetings were her only point of contact with other therapists:

> My colleagues – 'Do bleep us'. They were at the major hospital. You know to have to bleep somebody because you didn't know which bit of paper to use for something or other. You just felt so appalling.
>
> *Did you never see the other speech therapists in the department?*
>
> There were meetings. And I had my paediatric colleague.

Inadequate facilities including accommodation and equipment were not uncommon with many therapists having to struggle to improve conditions. Many older therapists had difficulty finding appropriate spaces for treatment. Rachel described having to use the sluice room of the hospital owing to the inadequacy of speech and language therapy accommodation:

> If there were two therapists there one would always have to go up on the wards but after a while that became impossible. So as I say I spent a great deal of my time then treating in the sluice room with a nurse going in and out!

The low priority accorded to speech and language therapy in terms of facilities was highlighted by Mary. She explained how in the fifties she was removed from her clinical space when the dentist turned up unexpectedly:

> .....one clinic I worked not in the dentist waiting-room but in the dentist's surgery at this clinic on the day they weren't there and if they happened to turn up unexpectedly I mean I was just chucked out.

Other participants were more successful in obtaining resources, though frequently this was dependent on support from medical staff. Many people spoke of improved working conditions but this was often hard won. Rachel told how she had moved from one room and the sluice room to a set of rooms with a secretary, but this was at great cost:

> .....you were never allocated anything until you struggled away in what I would call 'the martyr syndrome' - very much so. You literally had to martyr yourself. You had to prove yourself over and over and over and over and over again.

This section has highlighted dissatisfaction with conditions of work. These issues were related to lack of recognition. In many situations the resourcing of speech and language therapy had greatly improved but this had come after much struggle.

9.4 Medical power and the marginality of speech and language therapy

Chapters 2 and 3 drew attention to the health division of labour more generally in which the male-dominated professions tend to enjoy higher status and prestige than the female-dominated professions. A continuing theme arising in therapists' accounts of their working life was the influence of medicine on speech and language therapy practice. This is in contrast to the official account of the profession's history which depicts it as autonomous from medical control, stating that

> ....speech therapists were, and are, responsible for assessment, diagnosis, treatment and discharge of those under their care' (RCSLT: 49).

This section considers the profession's relationship with medicine in more depth. I examine the nature of medical control and the extent to which this has changed in

relation to clinical priorities in health care, organisational influence, clinical decision-making and attitudes.

There was evidence that speech and language therapy practice was dominated by medicine not only in being a lower priority than medical practice. It was also evident that priorities within speech and language therapy practice itself were influenced by medicine. In terms of medical concerns taking priority Paula commented 'we don't empty beds'. An important factor was that most speech and language therapy services are part of community health sector rather than the acute sector. Clare, who worked in a combined acute and community trust, explained that despite pronouncements about the importance of community care, the heaviest demand on resources came from the acute sector:

> Within this trust we've got a surgical directorate, a medical directorate, women and child health, us and facilities or whatever. The way it looks on paper - and nobody's been able to explain it to me otherwise - is that they've overspent and we've bailed them out. We've ended up with less of the budget the following year, the implication being if we didn't spend the money we didn't need it in the first place. That is the frustration of working in a joint acute and community trust, despite the fact that the message is 'Yes we're moving towards community. Yes, we understand the importance of community services' it's not the reality. But you can see it from the provider's point of view. The heaviest push for monitoring is on acute services and on waiting lists.

Pressures from medical concerns were evident in speech and language therapists' interactions with doctors, both in the community and acute sectors. Jeanette, for example, recalled an incident at a study day in which a GP expressed a lack of interest in speech and language. She was concerned about apportioning money for therapy for a child with a stammer, stating that she would prefer to spend the budget on medical treatment:

> ....the first thing she said was 'I know nothing about speech therapy. And I don't refer to speech therapy'. That was her opening remark. And it got worse. She was talking about that they have no figures for speech therapy so they can't apportion something or other and she got a bill for £3,000 for a stammering child that she hadn't agree to and she could have had a breast reduction or something....

A number of therapists commented on the higher profile of speech and language therapy in acute hospitals. Many felt this was due to the profession's role in the treatment of dysphagia[36]. This required a high degree of liaison with nursing and medical staff and thereby increased the visibility of speech and language therapists. This contrasted with their less visible role in community settings, as Sue explained:

> .....our adult department has a higher profile within the hospital because it's more of an acute model. And they're seen in an about the wards and they mix with doctors and nurses and they teach the nurses how to do swallowing work and I think the adults have a much higher profile than we do. I wonder whether being out in the community has something to do with it - the fact that we're sort of dispersed - we're not all hospital based.

Jeanette stressed the significance of swallowing work in terms of its implications for the medical care of the patient as compared to the treatment of communication impairments. This meant that hospital doctors and GPs were now more likely to refer patients for dysphagia than for communication problems:

> .....you know I get more referrals from dysphagia in the community than for dysphasia because that's very obvious - someone is eating and they're coughing and choking and the doctor's being constantly called because they've got a chest infection and they've heard that speech therapists can do something about that. And so they call you in and 'Oh - you happened to find out the patient's dysphasic'. But it's not an obvious thing and it's not impinging on them - why have they got to spend some money on somebody that's got a communication problem - it's not really a problem for them.

Section 9.3 pointed to changes in the organisation of speech and language therapy services from being directly led by doctors to developing more autonomous management structures. Mays and Pope (1997) found that managers were still positioned relatively highly within provider organisational hierarchies with most managers being directly accountable to a manager on the trust board or to a manager one tier below board level. Most managers also retained budgetary responsibility for their department. Marion spoke of the positive aspects of having control over the budget which she could use to fund new initiatives:

> I like the ability to make things happen which because I've got the whole budget and we can adopt a fairly flexible approach to the way we run the department we can just make things happen....so people can say 'why don't we do this? And we say 'yeah let's do it' and it happens'.

[36]Swallowing difficulty, including as a result of stroke.

However, the data indicated that there were ways in which medicine continued to exert control on the way speech and language therapy services were provided. Mike perceived the NHS to be '.....slipping back towards the old system of the medically-orientated, medically/nursing led model'. Because of this speech and language therapists were 'always having to prove that they can do it'.

A point touched on earlier in this section was doctors' power in making purchasing decisions via fundholding.[37]Clare spoke at length on management arrangements for contracting in speech and language therapy services and the effects these were having on the type of therapy provided. A complex process for contracting had resulted from the purchaser-provider split which was leading to fragmentation of the service:

> .....we're in the situation now of being pushed and pushed to sign different contracts with different stipulations for different GP fundholders. I went to see one yesterday with two GPs and they want to buy something completely different from people who are working in the same surgery. And so the fragmentation from that point of view is an enormous frustration....

Budgetary control by GPs had the potential to affect referral patterns in general. This could be jeopardised if GPs were ill-informed, as Harriet explained:

> .....going to my own GP who said 'Speech and language therapy is a closed book to me'. I thought well if you don't know and you're a source of referrals for us - and now they've become fundholders where does that leave us?

It was noted earlier that official accounts state that speech and language therapists are (and always have been) autonomous as regards clinical decisions. Data from this study did not support this view unambiguously. Adrienne recalled that forty years ago she was responsible for diagnosis and treatment planning. Nevertheless, she had to have medical authorisation before discharging a patient. A major change was that doctors, including the clinical medical officers with whom she worked, now treated her as an expert in speech and language impairments:

> I've had good experience within the clinic with the medical officers who've treated me as an expert. If I felt that perhaps I would discharge that child or put him on long-term review and I explained my reasons I'd say 'He's still got a lot of problems but for this, this and that reason

[37]These arrangements are currently under review, with purchasing decisions expected to be made by newly-established primary care groups. It is not yet known how this will affect speech and language therapy services.

> I'm going to do so-and-so', she'd say 'Fine. Whatever you think. Let me know if you decide to take him on again'.

Several people noted continuing medical involvement in aspects of their work, at times necessitating deferral to medical opinion. Diagnosis appeared to be an area of dispute, doctors questioning the validity of a speech and language diagnosis in some instances. Margo explained that therapists were often in a position to make a diagnosis but were unable to do so prior to the child's appointment with the consultant:

> Very often we're one of the very first agencies to be involved with the child who is showing strange interactive ability at quite an early age, long before they're seen by a consultant. And there we are, stuck knowing that this child is probably is on the autistic continuum - you've got to know the child quite well. We can't say anything, consultant might say something and you're left like a lemon without this professional clout even - sometimes even in your area to be able to make a diagnosis before a consultant has.

She also pointed that when therapists did make diagnoses these could attract cynical remarks from medical personnel, as in the case of one dyspraxic child:

> ....a child that I felt needed to have a special assessment at the .....*(institution)* and the CMO who was involved said to the mother 'Oh. Dyspraxia. That's the in-word at the moment'. And I thought how dare she. And I said to the parent 'We don't make the diagnosis lightly at all because we know it's going to be a long-term thing'.

Earlier comments in this chapter highlighted both positive and negative attitudes of medical staff towards speech and language therapy. Sally, who qualified in the sixties, noted that the many of the GPs with whom she worked enjoyed their power, were not receptive to colleagues who were keen on multidisciplinary collaboration and were generally not interested in speech and language therapy. When GPs went against the grain they were shunned by their peers:

> There was one GP who worked here for a time who was a young person who was extremely interested and extremely receptive. He was so interested and receptive that the partnership that he was working for got shot of him pretty quickly. I think it was because they found his whole attitude much too challenging.
>
> *What was his attitude?*
>
> Well his attitude was involving other professionals, having much more of a multidisciplinary team approach. I think they didn't like that at all. I think they do like to be the arbiters of what is right and what is wrong and what is necessary and what is not.

Rachel felt that hospital doctors' attitudes were changing and that therapists and doctors in her particular unit were on an equal footing, so that the medical consultant with whom she worked treated speech and language therapists as consultants in their own right. It was suggested earlier that speech and language therapy had a higher profile in hospital settings. These comments appear to support this observation.

This section has underlined issues of power in the relationship between medicine and speech and language therapy. The accounts of the interviewees reveal a complex picture in which therapists appear to act autonomously in some instances and others in which they continue to be dependent on medical approval. The next section considers to what extent gender may explain the marginal position of speech and language therapy according to the views of the interviewees.

9.5 The marginality of speech and language therapy: a gender issue?

In this section I look at gender as an explanatory factor in the marginality of speech and language therapy. I continue with the themes of working conditions, including pay and career structure and speech and language therapy's relationship with medicine. I also consider the significance of sexuality in workplace culture and relations with men in positions of authority, not only medical physicians.

It was seen in Chapter 6 that the female occupations were deemed unsuitable for boys largely because of the low pay. By and large pay was not seen as important for girls on the assumption that their wage would be seen as a 'second income' once they were married.

Several respondents felt the low profile of the profession was a gender issue and that the balance could only be redressed if the pay was increased and more men entered the profession, as Georgia indicated:

> *Do you think the fact we're mostly women has anything to do with it?*
>
> I think that could be factor. It's probably a strong factor and the salary as well. The salary needs to be upped accordingly and we need to attract more men. I think that's basically what it is to be honest.

According to Liz, lack of career structure was also a gender issue, with men not wanting to enter the profession because of this. She noted that men applied for positions which were not 'what the vast majority of therapists are doing', setting their sights on promotion. She was doubtful, however, that improving the career structure in itself would draw men into the profession and implied that the usual reason for entering the profession (caring) was not a draw for men:

> I don't think yet the men are as interested on the whole in the sorts of bits - I think there would be even more unfilled posts than there are now, but how it would look to the outside world I don't know, probably quite different. Unless there's a better career structure or whatever I can't - but I don't think even that would draw men in because I don't think that's why people join the profession.

Chapter 2 drew attention to changing patterns of occupational segregation whereby women are entering previously male-dominated areas, though they still occupy the vast majority of 'caring' jobs in paid health work. Chapter 2 also highlighted the continued existence of cultural factors in the workplace which serve to discriminate against women. The current state of flux in gender relations in employment was reflected in therapists' differing views as to women's status in organisations (the NHS, in this instance). For Harriet, a newly-qualified therapist, the visibility of women in management roles was an indication that gender was no longer a significant factor in women's career development.

> I'm working with so many females and because I know there are people in quite high positions and they are females that have reached high - I mean our therapies manager is a woman and most of the hierarchy in this district they're women. So as far as I can see they've achieved, they've done well. I don't view it because they're women.

Indeed, there were clear indications that both male and female therapists were being encouraged to take on leadership roles in the NHS often in a generic capacity in addition to their management responsibilities for speech and language therapists. Nevertheless, this data supported evidence of continued gender segregation within speech and language therapy, thus echoing divisions which still exist at certain levels of the NHS management structure.[38] Chapter 4 showed that the few men in speech

[38]Women are disproportionately represented in senior management roles in community units, while male senior managers are found in greater proportions in acute hospitals (IHSM Consultants 1994). The IHSM survey of top managers also indicated that female managers were more likely to be unmarried and without children than their male counterparts. Twenty-three per cent of the women

and language therapy are concentrated in academic work and occupy a disproportionately high number of management posts. Jeanette commented on this:

> ....all the guys that were on the course at college - they're all managers in some sense rather or very much more successful - .....*(SLT)* has written loads of articles - he's one of the big lecturers at .....*(College)*, ...*(SLT)* is manager in .....*(town)*,.. ....*(SLT)* is a manager over in somewhere else....

As regards sexuality with the workplace, some accounts made explicit links between medical power and male control and the way this acted to subordinate female colleagues including speech and language therapists. Other participants recalled such experiences but put these down to 'normal' male behaviour. Several forms of male coercion were described including those not overtly sexual. This underlines the point made in Chapter 2 that sexual harassment in and of itself is inadequate for conceptualising sexual politics at work. Rachel described how in the sixties a male consultant used controlling behaviour over female staff. As regards speech and language therapists this involved avoiding contact to the extent of keeping them out of sight. He used other female staff including the ward sister to maintain control. I asked what would have happened had she approached the consultant directly:

> I think I would have got very short shrift. He was a very nasty piece of work indeed! And he didn't like women. That was particularly what it was about. So I mean....
>
> *How did that come across in his behaviour?*
>
> Well, as I say it was more from the - what's the word I'm looking - his reputation which proceeded him or what other people said about him. I remember on one occasion coming up to see a patient on the ward when he happened to be doing his ward round. And the normally very helpful sister I mean snapped my head off because there was no way she would be distracted even for half a second in anticipation of the consultant arriving on the ward for his ward round. And I was told not to be on the ward at that time.

Chris noted that male doctors made remarks to colleagues which were 'pretty crass and pretty insensitive' in the presence of therapists. Unlike Rachel, Chris did not see this as a problem, appearing to be caught up between two opposing views - one that labels such behaviour is offensive and the other that it is acceptable:

> .....afterwards I think well, perhaps I should have been upset but I didn't find it particularly offensive.

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were single compared with 2% of the men and 50% of the women had no children compared to 7% of the men.

This was also apparent when she recalled another incident involving a male lecturer whose behaviour students said was 'sexist'. Firstly, she said this was not obvious to her but then said she could but that it did not offend her, likening such behaviour to that of her brothers:

> I come from a very male family and I think there is that aspect in the sense of finding my own niche and I feel very comfortable about that. I sort of don't feel I have any prejudice against me in that area because I'm female - but then that's again possibly because I'm not looking for it. You know, I mean I often think you know .....*(doctors)* here are exactly like my brothers - you know with all that that entails.

Such examples were not confined to male-female relations in health care settings. Sylvia described how as a young therapist in the fifties a headmaster propositioned her when she entered his office. She commented that many older therapists could recall being in 'dodgy situations'. Implicit within this remark is the idea that such behaviour was more prevalent in the past. This perhaps relates to a perception that legislative change has led towards a resolution of the problem[39].

This section has indicated that there is a correlation between gender and the career paths of speech and language therapists, echoing the quantitative analysis presented in Chapter 4. Career incentives involving pay and promotion were seen as vital to attract men into the profession. Of course, this assumes that women are not interested in pay and promotion and indeed do not need them. This goes against the evidence provided in Chapter 8 which showed that many participants had achieved career success and that some were self-supporting and required a 'breadwinning' wage.

These data highlighted a number of points in relation to sexual power at work, including the notion that sexually discriminatory behaviour is no longer as prevalent as it once was, that the definition of harassment is open to competing interpretations and that the range of controlling behaviours is diffuse. A final point was that gendered power relations were not confined to interactions with doctors and need to be considered within the context of sexual power at work as a whole.

9.6 Conclusion

The data discussed in this chapter pointed to a general view amongst speech and language therapists that the profile of the profession remains a problem. Though the image has to some extent improved, there was a feeling that there is still widespread ignorance as to the nature of the job, including the perception that it requires little training and is concerned with the cosmetic aspects of speech.

There also appeared to be a misconception regarding the scope of speech and language therapy work and the extent to which the career structure was 'hierarchical'. The pay and conditions of speech and language therapists reflected the marginality of the occupation within health care services and there was evidence of struggle to improve working conditions against considerable odds.

Section 9.4 highlighted the significance of medical power at the levels of both organisation and ideology. Despite official accounts which have tended to play down medical influence on speech and language therapy and government reforms which have sought to emphasise community care, it was clear that medicine was still an important influence on speech and language therapists' work.

As regards the influence of gender on the marginal position of speech and language therapy, there was a view that recognition could only come with an increase in the salary and the consequent entry of men into the profession. The more influential occupations with higher profiles and stronger claims to better pay and conditions were the male-dominated professions of medicine, psychology and dentistry. The data also pointed to the overarching theme of male power at work in both health and education settings. These data thus support the theoretical data on women's employment which noted patterns of gender-segregated labour in which women in all occupations appear to occupy the lower paid, low status positions.

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[39]Sexual harassment is illegal in the UK in so far as it can be interpreted as an act of sexual discrimination as defined in the Sex Discrimination Act of 1975 (see Kitzinger and Thomas 1995).

Chapter 10

Science and speech and language therapy practice

10.1 Introduction

The thesis thus far has raised a number of themes with regard to the significance of science and gender in speech and language therapy. A major finding was that while the education, research and professional discourse are science-dominated, therapists in the study entered the profession in the main for the applied, therapeutic aspects of the job. A second theme concerned the fact that though participants had gained a science-based qualification, they by and large lacked confidence in their scientific abilities. A further thread was around the idea that caring or 'emotion work' (deemed typically female) could be complex and demanding therefore challenging that such skills could be learnt 'on-the-job'. The findings reflected ambivalent views around the gendering of emotion work. On one level there appeared to be an acceptance of the dominant view that women are innately suited to emotion work. On another level this view was challenged.

In this chapter, I explore the role of science in speech and language therapy practice in depth. Chapter 4 pointed to the dominance of biomedical discourse in speech and language discourse in diagnostic categories. Here, however, I consider the extent to to which the everyday practice of speech and language therapy may be characterised as 'scientific' by drawing on the characterisation of science developed in Chapter 3 and the insights of the interviews in talking about their work. I will briefly reiterate the main features of scientism as applied to health care before examining speech and language therapy practice in relation to these features.

Three important facets of science which had a major influence on the medical approach are a belief in the rationality of medicine to 'cure' illness, a belief that an understanding of the parts of the body will lead to an understanding of the whole

(including the separate consideration of the body and mind) and finally, a belief in the idea that the object under study (in this case, the patient) is better understood by taking a distant, unemotional stance.

The three sections which follow explore the science-non-science dichotomy in relation to speech and language therapy, beginning with the notion that the rationality of the human subject can 'cure' disease. This is followed by a consideration of the reductionist approach in health care which sees the body (and human communication) as a mechanism to be 'fixed'. The next section examines the idea of the 'scientific' health care worker as detached rather than involved, who is seen to make 'objective' rather than 'subjective' judgements. Lastly, I consider the image of speech and language therapy as a 'scientific' profession and how being a female-dominated profession may influence this.

10.2 Rationality and the 'cure' of human communication disorders

In this section I consider rationality as applied to the treatment of human communication disorder. I look at the extent to which therapists view treatment as a rational, orderly process with quantifiable outcomes. I first look at the issue of therapy as 'curing' or 'caring'. I then look at measurement of improvement in therapy.

A number of participants commented on the way in which therapy for human communication problems was presented in their professional education as an orderly, linear process involving the medical paradigm of assessment-treatment-cure. As Sally commented,

> .....when you come out of college and your head is very full of theory and all sorts of ideas. Things seem quite easy in a simplistic way – 'there is the problem, you know what to do about this problem - you assess with this test and then you use this programme and Bob's your uncle'.

Similarly, Sue, on first leaving college, felt she had to 'cure all these people'. There was a clear tension in the accounts between the archetype of scientific, rational health care interventions and those which were more difficult to define as such. The

majority of therapists highlighted the apparent conflict between the two as will be seen later. One interviewee, Chris, had a particularly scientific view of speech and language therapy practice. She likened her approach to that of doctors who were 'problem-solvers' and 'if you put it like this you do it like that'. Chris saw the therapist as someone who through reason and logic found 'the solution' to problems; the diagnosis led logically to the treatment:

> .....if you've got your diagnosis right and your intervention is right then your outcome will be right.

From diagnosis treatment progressed in an orderly fashion with a 'beginning, a middle and an end'. She placed priority on 'curing' the problem. This discouraged her from working in fields where cures were not clear-cut such as aphasia, as she explained:

> I like to have a definable problem...I like to have a problem that's quite difficult to sort out but once you have sorted it out there is a solution to it. I think that's where I'm put off with aphasia. With aphasia, yeah, I can sort out the problem, but the bottom line is that you aren't going to do anything about it in terms of impairment I mean. I'm not saying you can't do anything for the patient. But I'm talking about the impairment. If you take the person away from it and you look at the disorder. I mean the thing about .....*(disorder)*[40] is, that it's very defined, it's very clear-cut and it's very remediable.....

She spoke of not wanting to work in aphasia because it was 'too complex'. Thus implicit in the idea of 'cure' is the selection of definable problems for treatment and a tendency not to deal with complex problems where improvement is more difficult to measure:

> *What was it about .....(disorder) that you found interesting?*
>
> That's quite easy - it's the fact that you're working on the periphery of the body and you get results. I like the feeling of having an effect. I don't like .....that's why I could never work in aphasia - I'd get too frustrated with it. I feel very dissatisfied with those sort of.....those language-based problems. They're too complex for me!

The other therapists did not, however, see speech and language therapy practice in terms of a linear process leading from assessment to cure. Most perceived a conflict between the apparently rational, scientific approach to health care and the work that they did as speech and language therapists. A number of therapists acknowledged the

fact that there were aspects of speech and language therapy where a 'cure' could not be effected. This often conflicted with the perception they had of the work on leaving college. On occasion this meant that newly-qualified therapists had unrealistic expectations of what they could achieve, particularly when working in isolation. Sue now supervised new therapists and was able to help them overcome these misconceptions:

> I would have liked to have asked and I can give them the answers that I would have liked to have heard like 'No I don't know what to do with that one either. And you've probably done as much as you can and you're going to have to be realistic and say that's as good as it's going to get'. And I can say that with twelve years experience. 'Thank goodness for that'. But nobody gave me that reassurance when I first qualified and I thought I had to cure all these people! When I couldn't I felt awful.

The emphasis on 'care' rather than 'cure' in speech and language therapy arose in the context of health care interventions which 'saved' lives or enhanced the 'quality' of life. There was a clear perception that the NHS continued to prioritise life-saving interventions over quality-of-life interventions. The accounts highlighted certain ambivalences around this dichotomy. One argument related to the idea that nurses were indispensable owing to the fact that their work involved the saving of lives. On the other hand, life would go on without speech and language therapists, as Eileen put it:

> .....we are also not a kind of life-threatening service. We don't deal with people with life-threatening difficulties or very few. And therefore we provide a quality, don't we rather than - nurses are actually indispensable whereas obviously - I mean life would go on without us. It's the quality effect I think we have.

There was a tendency in some accounts to see quality-of-life and life-saving as in a sense dichotomous and mutually exclusive, with the former seen almost as a luxury and the latter as crucial. Vicky's account highlighted an ambivalence around this notion. At one point during the interview she expressed a strong view that the 'basics of life' were important to establish before thinking about human communication. This implied that communication was *not* a basic necessity of life; that the definition of 'reasonable health' does not encompass communicative well-being. In contrast the life-saving operation is imperative.

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[40]The speciality has been omitted for reasons of confidentiality.

> ....with reducing resources, I mean if you look at the human hierarchy, unless you're in reasonable health you can't think about your communication unless you've got the basics of life you're not going to move on and think of communication. Maybe you've got to do the life-saving operation first.

In contrast in another part of the interview, Vicky said she felt speech and language therapy was a difficult area to get across in that communication affected all areas of people's lives:

> .....it's difficult to describe to other people what you do. I think it's really difficult to provide a therapy for, I really do, because it bleeds into every area of people's lives and education and everything.

Similarly, Sarah underlined the significance of communication. For Sarah it was so fundamental that people tended to ignore the implications of losing their ability to communicate:

> .....it's too fundamental, too threatening for us to look at what it would mean to lose our communication skills - because it's about you and the rest of your being and personality is so tied up in it as well, I don't know.

These opposing views perhaps reflect contradictory notions of speech and language therapy's work as seen in Chapter 9.

Chapters 3 and 4 drew attention to scientific health care's predilection for quantification in research design and as a means to measure progress in therapy/treatment. Such an approach was often seen by the study participants as inadequate to capture what might be termed 'subjective' gains in therapy. Many interviewees spoke of the dominance of the scientific approach in evaluating health care interventions and the way these conflicted with the apparently 'subjective' changes which accompanied speech and language therapy input. In Barbara's opinion the most important indicator of effectiveness for therapy with people with cleft palate was how their speech was perceived 'outside the profession'[41]. This contrasted with the more easily measured, 'scientific' measures such as levels of resonance and accuracy of articulation:

> .....if we are looking at levels of articulation or deviance from that or according to anatomical structure or levels of resonance you've got certain instrumentation that can help you with that and you can sit a child down and you can have people repeating certain phrases, phonemes,

[41] I am assuming by this she means non-speech and language therapists.

whatever it might be. But at the end of the day it's how they appear in connected, spontaneous speech which is going to be the thing that will influence someone's perception of that person's speech outside our profession. And that's a very difficult thing to measure.

Problems requiring long-term input were frequently seen as those presenting the most thorny issue as regards 'outcomes'. As was seen in 9.4 doctors, including GP fundholders could be sceptical of speech and language therapy because it often dealt with problems for which there was no easily demonstrable cure. Several therapists mentioned special needs, including Jeanette:

.....they're certainly not interested in special needs - you know paying for speech therapy in special needs.

Why's that?

People with learning difficulties rather than special needs - what can you do? - what can speech therapy do for someone who's got a learning difficulty?

Other therapists felt quantitative measures were inadequate to capture behavioural change as indicated by Harriet who had been running a communication group for people with dementia:

.....there's definitely been an improvement in the group members in that they're participating more and that they're forming relationships with people and that they're going away from the groups - for example there's a lady that left the group after the second session, went back to her armchair and tried to tell the lady next to her about what we'd just been doing. So we'd actually given her something to talk about rather than having the TV on all the time. And how do you put that into numbers? I mean that to me is a real plus because she'd got a subject to talk about and she wanted to share it.

She later highlighted the difficulty of using quantitative measures to capture human behaviour:

.....at the end of the day you're describing individuals and how well they're doing and some things seem hard to put into numbers to be honest!

Several therapists drew attention to the fact that the 'rational' approach involving quantitative measures and an emphasis on 'cure' continued to dominate health care in the nineties. Ironically, however, these judgements were influenced by the need for cost-containment. Barbara, for instance, underlined the fact that improvement could take place over a number of years, but financial constraints limited the amount of therapy it was possible to give. Her account illustrates a tension between what she

perceived to be tangible improvement - 'very encouraging progress' and the difficulty 'justifying' this to purchasers:

> I don't think it's appropriate after six months to say to somebody who's maybe made very encouraging progress and has a long way to go at the end of six months 'Right that's it. It's up now. No more'. I think you can get improvement over a period of years, but it's very difficult to justify that with purchasers and health agencies and everything else, isn't it?

There was a sense in which financial control over health-spending as embodied in the health reforms of the eighties and nineties was seen to provide a 'rational' means of priority-setting. This had now brought therapists to account for the services they provided. It was apparent that Barbara believed speech and language therapists had in the past provided therapy imprecisely 'helping' patients get better, There was now a requirement to be 'precise'. Paradoxically she commented on this after explaining the difficulty of encouraging children who had achieved 'good speech' to transfer this into other situations:

> Another very interesting thing that we're looking at the moment is the sort of psychological overlay too which occurs sometimes in children when they are capable of very good speech but don't always use it. That's another interesting field as well. But I think this is where we fall down at times. It's a difficult thing, really, how we will improve on it...
>
> *Is it a failing or just a very difficult thing....*
>
> No - I don't think it's a failing as such - but I think for a long time the profession thought well it didn't matter too much. We didn't need to be accountable while we were 'helping them to get better. But now we have got to be more precise - we've got to be able to give some results of outcomes, we've got to negotiate contracts, we've got to say 'Right. We're taking this patient on and after so many sessions we will be looking at this or re-evaluating that'.

Sue similarly underlined the difficulty of showing improvement in quality of life. According to Sue, health care priorities were still focused in the main on easily measurable life-saving interventions on not on therapies such as speech and language therapy:

> .....we're in a trust that doesn't - they're not the worst - but they don't quite have an appreciation of what speech therapy does. It's not a life-saving something or other. It's quality of life and that doesn't count.
>
> *In other words as long as your hearts beating and you have no quality life it doesn't matter!*
>
> That's right. And you can't count - you can count someone who leaves special care and say 'You're saved, good-bye'. But it's back to this business of outcomes and audit. How do you outcome quality of life? You can't and until you can do that - especially within special needs.

This section has highlighted the continued dominance of science on speech and language therapy practice, both in terms of the emphasis on health care interventions which lead to a 'cure' and on the assessment-treatment-cure paradigm to which medicine (and speech and language therapy) have historically aspired. While there was a tendency within the profession to follow this paradigm closely, many therapists spoke of the tensions involved in adhering to the scientific, biomedical model. 'Objective', quantitative measures could be inadequate to show the effectiveness of therapy. Furthermore 'scientific' measures could be politically motivated, an irony given that archetypally the scientific approach is seen to be 'above' politics.

10.3 Reductionism in clinical practice

The last section focused on health care interventions as 'rational' processes. In Chapter 4 I noted the importance of the taxonomic approach in the scientific armoury of the health professions, with diagnoses made on the basis of symptom clusters. It was argued that focusing on individual symptoms epitomised the scientific approach, as the phenomenon in question is examined by reducing it to its component parts.

Here I consider the extent to which speech and language therapy focuses on diagnosis and secondly I discuss the tensions arising from this, including cultural and social factors which may influence the outcome of therapy.

The importance of diagnosis was underlined in relation to being essential to 'good' therapy in terms of the time spent on diagnostic procedures and in relation to its political importance with regard to status and resource provision. As was seen in 10.2, Chris held to the idea that treatment followed on logically once one got the diagnosis 'right'. It was evident from the interviews that a major portion of therapists' time was spent not on 'therapy' but on assessment and diagnosis. This information was then passed on to other professionals or carers who acted on the therapist's advice. Most of Liz's work in mainstream schools was taken up with assessment:

> I'm not actually doing any therapy with them. All I'm doing generally-speaking is assessing them. And even if I see them more than once it's usually to reassess them and find out what progress they've made. All the work is done by the teachers on my advice.
>
> *So you're very much in a consultative role, aren't you?*
>
> Very much so.

Chapter 9 highlighted the political nature of making diagnostic pronouncements in that doctors may query the 'truth' of a speech and language therapist's judgements. It was evident that clinical diagnosis was an important part of the professional armoury, more so than 'therapy'. Jude felt that therapists in the UK were not valued for their diagnostic skills to the same extent as in other countries. Of interest is the fact that she equates diagnosis with being 'an important cog in that wheel, not 'therapy' - clearly the low status end of the work:

> The doctor will refer somebody to you for an opinion and a diagnosis which means you are perceived to be an important cog in that wheel rather than a doctor referring a patient to you because they need therapy. So the relationship is very different.

Aside from being bound up with status and power conflicts amongst health professionals, the making of diagnoses was also dependent on resource availability. Eileen explained that coming up with a diagnosis of autism had cost implications. She suggested that health professionals could withhold the diagnosis in the event that there were insufficient resources locally to provide special educational input.[42] This was not necessarily in the best interests of the child:

> .....if education is agreeing with those things they may have to come up with an offer of education. From a health point of view our responsibility is to diagnose and to offer follow-up programmes but perhaps the cost implication is slightly less in a way.
>
> *How do you mean?*
>
> Say if this child has autism - if the educational psychologist immediately says 'This child has got autism I will say If the child's got the right education at three we can hopefully find out the problem. If you and I give the right help by three maybe by five he can go to a mainstream school rather than a special school'.

[42]Ussher (1992) underlines the significance of political factors in the making of diagnoses including the values of the expert and resource issues, 'It can be argued that as well as being subjective, diagnosis is heavily coloured by the values and politics of the expert, and by the service demands being made (i.e. if services are scarce professionals may chose not to recognise or diagnose a particular problem) and thus the categories adopted are often arbitrary and invalid' (p.44).

A number of participants highlighted the problems of being disorder-focused. This could detract from thinking 'creatively' around therapy strategies, focusing on the disorder rather than the person and paying less attention to environmental social and cultural factors.

While the validity of speech and language therapy diagnoses were rarely questioned directly during the interviews, many people drew attention to the tendency of some therapists, particularly those who were newly-qualified, to focus on the disorder rather than on therapy or the broader context in which therapy takes place. This occurred on a number of levels. One related to the way in which new therapists tended to focus on the diagnostic rather than therapeutic aspects of the work. Lynn felt therapists were taught in a 'rigid' way so that new recruits lacked the creativity and flexibility demanded by therapy. This meant they concentrated unduly on assessment:

> It's the creativity, it's the - we're dealing with people and no two people are exactly alike. What works for one person doesn't work for the other and you have to be very flexible. And maybe if you're taught in such a rigid way, unless you have a natural ability anyway to be creative, it can take a long while for people to learn to be creative. I see it with the new recruits we have. Maybe scientifically they can probably tell you down to the last logogen exactly what is going wrong. But in terms of the creativity and you've got somebody sat there. You can't assess indefinitely. You've got to be able to do something.

There was evidence that both professional education and organisational values played a role in perpetuating a disorder-focused approach in health care whereby the person of the patient 'disappears'. Sally commented that young therapists who she supervised needed reminding that children seen for therapy were not speech problems 'with a name attached':

> Very often with the young therapists when we're talking about a child I say to them 'You know that's only a part of him. When he goes out of here he's not a speech problem with a name attached. He's a little boy who just happens to have a speech problem'.

As noted in Chapter 7, drives to contain NHS spending had resulted in a decrease in the time therapists spent with patients and thus it was becoming increasingly difficult in an acute setting to do more than treat 'the disorder'.

Many therapists emphasised the importance of factors outside the diagnosis-treatment paradigm which affected the outcome of therapy. This included acquiring an understanding of how to work within teams and organisations. Maxine described how she entered a school wanting to set up programmes because 'that is what you were told was the thing' with no knowledge of the school hierarchy:

> .....if you're in a school fitting into a different structure - a different philosophy of care - you know I used to - I can remember going into a school for severe learning difficulties and wanting to set up programmes with them because that's what you were told was the thing. But having no idea of the structure and the hierarchy and how to get support for that work.

Sarah recalled being irritated by mothers who failed to arrive on time for their appointments. She later realised that she had failed to appreciate the difficulties clinic attendance posed for these mothers. She felt a holistic approach in therapy was essential taking into account the therapist, the organisation, the patient and their environment:

> .....I mean it's the holistic approach - it's you and the organisation and it's the patient and their environment and what affects them - I mean I used to find it terribly irritating when people were late for their appointments and would come in with these snivelling kids and would proceed to rip my books. It's only when I had children myself that I thought 'Good God, no wonder these poor women were arriving in this ragged state!' And I had car - they were getting two buses, dragging along all these other children, picking one up from school - but my focus was on I'm here doing this wonderful work....

Lynn further highlighted the importance of taking social and cultural factors into account . She pointed out that factors such as race could unwittingly affect the way a therapist treated (or did not treat) a client. She felt steps should be taken to develop anti-discriminatory practice:

> There should be something done about anti-discriminatory practice - that sort of issue because we are living in a multi-cultural society and you can be taking a therapist from very twee shire county where she'd never seen anybody black, Asian or whatever. Whatever values she holds are based on her own experiences there and she may come to one of the training colleges which are often attached to major urban areas where she may actually see somebody for the first time. It is her first contact with a black person or an Asian person and she's got all those values - rightly or wrongly - I'm not going to judge them - but that can affect how she sees that person, how she treats that person, or not treat them.

This section has shown that diagnosis is regarded as important in speech and language therapy practice both from scientific and political points of view. It also indicated that a number of therapists had difficulty reconciling a disorder-focused

approach with their view that therapy was influenced by many other factors including the therapist's creativity and socio-cultural factors.

10.4 The therapist as detached expert

The final aspect of the scientific approach I explore in this chapter is the extent to which the characterisation of the therapist/health care worker as 'detached expert' influences speech and language therapy practice. Given that many therapists enter the profession for the relationship with the patient (see Chapter 6), one would expect tensions to arise if indeed the idea of the therapist as distant and unemotional is still prevalent.

I firstly consider the theme of emotional detachment within the participants' accounts in relation to the professional education and as an approach to speech and language therapy practice (both therapy and management). I also look at the management of health care staff by a medical physician. I then look at the connections between speech and language therapy and the medical model in relation to maintaining emotional (and professional) distance. Finally, I look at therapists' critiques of this approach and how they have sought to change it.

Jude was of the opinion that the professional education of speech and language therapists placed emphasis on the 'doing part' of therapy rather than on the relationship with the patient:

> .....there's a very strong doing, task-orientated culture from the university days onwards which is around 'We don't think. We just do. This is what speech therapists do'. OK. So if you've got a child with artic, this is what you do. You don't have a relationship! The relationship doesn't fix it. It's the yellow card with S's on it! You know. It's the equivalent of a pill, it's the equivalent of a book or whatever it is. It's the doing bit.

Chris saw herself as 'issues-based', as someone who did not get involved in 'emotional issues'. There were other instances where the expression of emotions was seen to be undesirable, including those arising from the death of a patient. Harriet told of the death of someone she had been treating for eight months. This caused a severe grief reaction which spilled over into her home life. She dealt with this in isolation, rationalising that similar events would occur again in her career and that

she needed to distance herself; 'you can't let it get to you so much'. This was reinforced by Harriet's manager who appeared to 'switch off' from emotional issues. There was a fear that confronting her boss with the emotional aspects of the job would be met with incomprehension or suggestions that she should displace these onto other activities such as 'hobbies':

> ....as far as she's concerned when she gets home from work that's it. She's at home, she has a brilliant social life. From conversations with her just over lunch and things, it sounds like she can completely switch off from work. So I almost feel if I was to go along to her and say 'I can't switch off from work that she'd say You should. It's easy - you should get some more hobbies'.

The tendency to avoid or downplay the emotional aspects of working in health care was evident both within speech and language therapy and other professions. In one instance it was clear that the hierarchical power of medical personnel played a part in perpetuating an approach which failed to acknowledge the attendant stresses involved in 'emotion work'. Louise worked with patients some of whom had severe, long-term neurological impairments. Her job frequently involved dealing with issues around loss and grief. Louise clearly felt the need for support to cope with the emotional side of the work, but this could not come from within the team because everybody was affected:

> .....it's like any situation where you're having to deal with say loss or grief or whatever - everyone around you is affected by it. So they're in no position to help you and you're in no position to help them. So you really need to seek support outside of that immediate group, or from someone who's more on the fringe of the group....

The idea of counselling had been mooted but failed to materialised, in part because of a lack of action on the part of the medical consultant. Louise suggested the reason for this was the fact that he failed to appreciate the need for it because he did not work at the 'coalface':

> I think it's the attitude of .....*(consultant)*. I think he just doesn't realise that it's needed. But he's not working at the coalface with the patients.

The idea of emotional distance was bound up with notions of power and expertise. Several therapists commented that the image of speech and language therapy

portrayed in the media stemmed from the medical model which focused on giving advice rather than working in partnership with patients, as Sarah explained:

> .....there's a large element of that in our profession - there's a large wagging-finger element - a very punitive part that I dislike intensely and I think our image is bound up in that if you look at it across the media. I mean my sister - she's not an SLT – 'Oh yes they had a very nicely-spoken woman on there' and you know it is this sort of - we're trying to get away from but it is alive and well.
>
> *Where do you think that thing about shaking the finger at people comes from?*
>
> I don't know - I mean I think it's very out-dated - I mean I think it's probably linked into the old views which were in the medical model as well of you know - stop smoking.

There were indications of a correspondence with this image and the 'realities' of clinical practice. Lynn, for example, spoke of the tendency for therapists to focus on their own 'expertise' rather than on identifying with the parent's or client's experiences which may be influencing progress: Lynn also felt this derived from the medical model of 'take two aspirins':

> 'Why hasn't she done that?' We don't asked that. 'She hasn't done my work. What does she expect? Her child's not progressing'. We're quite egocentric about it, aren't we?
>
> *Yes. It sort of challenges our professional - it's a challenge to our power in a way, isn't it?*
>
> Yes. And this medical model - because we are the medicine we're equivalent to the doctors 'Take two aspirins. Have your speech therapy and all will be right'. And they get very annoyed about it.

There were clear indications of moves away from the therapist acting as detached expert and towards using a more facilitative approach. Jude spoke of having made this transition. This came across to her early on in her career at end-of-term meetings with parents. She described how she became aware that she based her assessment of a child's progress from her own point of view, not the child's mother's:

> 'Oh she's really made progress and if you look at this and....And I remember thinking This is such crap. Who do you think you're fooling?' I remember saying it to myself 'What are you doing? What the fuck are you doing?' And from that point thinking and the mother very often saying 'Yes but she still can't talk can she?' And I was saying 'She's eating better and she's making better eye contact'. But I was doing it from my point of view and I was not looking at how the mother was feeling about this and her desperation that she couldn't talk to her baby. Those sorts of things and this really strong sense that unless we start from where the parent is at and we really do look at trying to work in partnership with these people, we might as well just not bother. What is the point?

Like Jude, Sarah felt speech and language therapy needed to move away from the image of a profession which 'advises' or 'tells'. There was a need to identify with the client's point of view:

> .....we haven't really spent much of our time sort of thinking out ways of getting our message across in the most effective way. We advise - there's this whole thing of you know we recommend or we advise or we tell - we're very much - it's that model as opposed to involving people and actually getting them on your side or getting in their shoes to see what's going on in their lives as well.

There was a clear shift in some services to acknowledging the 'emotion work' in speech and language therapy with some services taking active steps to introduce support systems such as non-managerial supervision. Jude was strongly committed to supervisory support structures to the extent that she felt that in not dealing with these issues the profession was 'irresponsible':

> .....all the feelings that come up in you - you're not going to understand those unless you look at yourself and look at your own stuff and you're own family and how patients fit into those. You're just not going to do that, are you?
>
> *You can't move on really.*
>
> No. And to expect people to do that without having the fear and the anxiety that that invokes in people is absolutely enormous. So yeah, I just think that there's something about the profession that is irresponsible - that we're asking people to deal with the stuff, the actual stuff of souls and communication and the essential bits about being human without giving them any sense of insight into their own stuff, you know...

At the same time, however, the rationalisation of health care services was leading to shorter patient contacts. This appeared to threaten the 'relationship' element of the work. As was seen in Chapter 6, this was a major draw to entering speech and language therapy. Pat regretted the fact that this appeared to be changing:

> We've had more time I think in the past - and I hope we don't lose this as a profession - to actually make a relationship with the patient.....

This section has highlighted a continuing tendency for 'emotion work' to be downplayed in organised health care. This occurred through the actions of medicine institutionally and the individual behaviours and attitudes of speech and language therapists and managers. This reinforced a continued tendency from the professional education to focus on the scientific aspects of human communication. Speech and language therapy practice, in the accounts of these participants, continued to

privilege expert knowledge and distance over subjective identification with clients. However, many interviewees were critical of this approach and were aware that involvement and partnership with service users went against the grain of the medical model. Current trends in the rationalisation of formalised health care appeared to be threatening the relational aspect of speech and language therapy.

10.5 A scientific practice: a scientific image?

In this section I consider the extent to which speech and language therapy is perceived to be a scientific profession according to the evaluations of the research participants. I also consider whether these therapists perceive gender to be connected to the image of speech and language therapy as scientific.

Previous sections of this chapter indicated that science heavily influences speech and language therapy practice. However, these accounts also indicated not only contradictory views as to whether the profession is scientific, but also pressures which encourage therapists to downplay the scientific elements of the work. Harriet, for example, felt that outsiders fail to acknowledge the large scientific component of the course:

> .....that's what's so disheartening because I think to myself - sometimes I feel undervalued and I just think 'I had to go through a heck of a lot of training' and we all do as therapists - you either do the four year or the two year course - we do - OK our knowledge of the medical side of things isn't obviously as in-depth as theirs, but we do study anatomy and physiology. We study psychology. When you rattle off the number of aspects we have to learn to get into this job, and I think 'Come on guys'. I mean.

The lack of scientific content as perceived by others was also reflected in some therapists' views of the work. Sue, for example, stressed the 'caring' elements of the job rather than its scientific aspects, which in her account appear to stand in opposition. This was in spite of the fact that her husband saw the work's scientific content:

> *.....in terms of your career - what's facilitated it or what's held it back? How much do you think it's to do with being a woman?*

: I suppose I could be very sexist and say that women are better at the sort of caring-sharing side. But my husband maintains it's because I've got a more scientific brain than I would reckon for. Whenever I describe my job to my husband he says it's very scientific - he's a government scientist and he would say 'Well that's a very scientific way of looking at things'. So I don't know whether it's because I'm a woman.

There was evidence to suggest that therapists were urged to play down the scientific aspects of the work, for example, by minimising the use of technical jargon when writing reports to GPs. Harriet felt this was unacceptable because doctors also used jargon when writing to therapists. By not using jargon therapists diminished their credibility. Harriet argued that in certain circumstances the use of jargon was justified:

I saw somebody who was transferred to me from another therapist. She felt that they knew nothing about what was going on with their voice and how the voice worked. And she was an engineer. So I immediately explained about the Bermoulli effect and the vocal cords. As soon as I threw in that term she was hooked and I realised that I was talking to someone I could use jargon with. When she left that session she said 'I feel I know so much more now and I understand it'. And she said that to meet someone who actually knows what they're talking about. And I thought 'We all do and we're told not to use jargon'.

There were also contradictory views on the part of therapists themselves as to whether speech and language therapy was simple or complex. Sarah's account reflects this ambivalence. One the one hand she felt it could look like 'YTS', but on the other it was heavily theory-based:

I can remember someone saying this to me – 'what is it YTS?' And it looks very simple but you have no idea of the thinking behind it. I know that's important but I do think sometimes we end up by doing simple tasks and we had all this theory behind it. But I think that's one of the reasons why people get bored with speech therapy, actually, after a while - bored with the clinical work because they know the theory of language but when they're actually sitting with the patient the - many of the tasks are quite monotonous and repetitious and the two seem unbalanced, really.

From the point of view of the influence of gender, the quote from Sue's interview above indicates that she has a low self-image as regards her scientific ability and that she equates the work with 'caring-sharing' which women are better suited to. However, she does reflect back and challenge this idea because her husband's view that the work has a scientific aspect. There is thus a lack of clarity in this account as to whether speech and language therapy *is* scientific and there is clearly a gender dimension to this which associates caring with women not science.

This section has pointed to a discrepancy between the actual scientific content of speech and language therapy practice and its image as generally lacking a scientific basis. Outside pressure was exerted to downplay the scientific elements and individual therapists appeared to struggle to acknowledge the scientific aspects of the work. Lastly, there appeared to be a dualism between caring and science, in which caring is equated with women and science with men.

10.6 Conclusion

This chapter aimed to highlight the extent to which speech and language therapy practice is based on the scientific, biomedical model of health care along the three dimensions of rationality, reductionism and emotional detachment. It also aimed to draw attention to the tensions arising from the scientific emphasis, given that the majority of therapists entered the profession for its potential value to people with communication difficulties. Finally, the chapter considered whether the image of speech and language therapy is one of a scientific profession, in the light of the analysis presented in the earlier sections of the chapter.

The data highlighted the continued influence on speech and language therapy of the scientific approach involving the key elements I have analysed in relation to practice. There was a tension between these and the 'caring' elements of therapy which involve subjectivity, a 'whole-person' approach and emotional involvement. There was ambivalence as to the scientific content of speech and language therapy and questioning as to whether women can 'do science', even when a large part of their work is science.

Chapter 11

Conclusion

11.1 Introduction

The concluding chapter of this thesis has three aims - to restate the gap in the literature this thesis has identified and attempts to address, to discuss the principle findings of the study in relation to the theoretical position developed in Chapters 2-4 and to consider areas which still remain to be researched.

11.2 Bridging the gap in the literature

This thesis has drawn attention to the long-standing concern within the speech and language therapy profession over its marginality in the health service. Over many years dissatisfaction has been expressed over the lack of recognition accorded to speech and language therapy, the poor pay and conditions of therapists in relation to other graduate health professions and the problem of retaining experienced staff in the profession.

As was discussed in the literature review, this problem has been looked at quantitatively in terms of staffing flows in and out and the profession and in terms of therapists' reasons for leaving the profession. The main concern of these studies has been to look at causative factors within the profession itself or within the lives of individual therapists rather than to explore links between speech and language therapy and labour market issues more generally. Looking outside the literature in speech and language therapy, I noted, for instance, that there appeared to be parallels with nursing, in particular, the lack of recognition also accorded to nursing. Were similar factors operating to cause the low status of speech and language therapy?

No attempt has so far been made to explore ways in which the sociology of work may shed light on the work of speech and language therapists. This is the first study

to attempt to do so. Sociological analyses have strongly contended that gender is a major factor in the marginalisation and undervaluing of certain areas of health care work (other than speech and language therapy which has not been subjected to such an analysis). As I pointed out in Chapter 1, sociologists have theorised that the division of labour in healing work cannot be understood without reference to the division of labour between the sexes. Given that speech and language therapy is heavily dominated by women, I considered gender as a factor in its marginalisation.

This thesis addresses a second theme, now acknowledged to be underdeveloped in the sociology of the health professions, that of the scientific content of nursing and the paramedical professions, as Elston (1997) has pointed out:

> ....sociologists of science have been slow to recognise that nurses and paramedical professionals study and sometimes do science (p.13).

The marginalisation and trivialisation of certain forms of work connote that such work is low-skilled and requires little training. As I pointed out in Chapter 1, to many outsiders this is how speech and language therapy is perceived. Yet I also underlined the fact that speech and language therapy has been an all-graduate profession since 1985 (longer than any other female-dominated health profession) and that its undergraduate curriculum has a highly scientific content, based heavily on biomedical knowledge.

Thus there appears to be an incongruence between the way the profession is perceived and the nature of the professional education. This mismatch is evident in outsiders' attitudes towards speech and language therapy, including those of medicine informally, during, on occasion, in everyday interactions, as I highlighted in the introductory paragraph of the thesis, and via the interview data.

11.3 Speech and language therapy: a caring image, a scientific occupation

The theoretical chapters highlighted the significance of the gender division of labour in which women predominate in caring roles, including as unpaid carers and paid health workers. They also highlighted the division of labour in the paid sector of health care work in which men are concentrated in the upper echelons of all the professions as managers, researchers and lecturers (a notable exception being GP work, a hands-on role which for some time has been dominated by men). These chapters also drew attention to occupational divisions in which men are seen to do 'scientific' work and women are seen to carry out the 'caring' functions. Gender divisions in the labour market, of course, reflect gender-stereotyped career choices, as was pointed out in Chapter 2.

Previous research has shown, as indicated in Chapter 3, that a number of health professions have 'scientised' in order to gain status. The male profession of medicine, for example, looked to Enlightenment science as a means of gaining recognition. Medicine presented itself as a benevolent force based on the scientific principles of rationality, reductionism and emotional distance. Chapter 3 highlighted the use of scientisation as a strategy to both delimit and challenge both inter- and intra-occupational boundaries. The gendered character of these struggles was also described. Research has indicated that appeals have been made to gender stereotypes in which men are deemed to be 'naturally' good at science, and women to be 'naturally' skilled at caring. Indeed, the latter function is seen as an extension of women's roles in the home'.

The empirical work presented in Chapter 4 showed that despite criticism that speech and language therapy is unscientific, its research, professional education and practice, as indicated by documentary analysis, adheres strongly to the scientific, biomedical model. For example, my analysis of a number of papers reporting the findings of speech and language therapy research in the main professional journal showed a considerable bias towards using traditional scientific methodologies, in particular,

experimental design. I further illustrated that though there have been challenges in recent times to this tendency, speech and language therapy research continues, in the main, to employ traditional research methodologies.

Data from the interviews carried out for this research indicated, not surprisingly given that 98% of speech and language therapists are women, that the occupation was definitely a career choice 'for a girl'. There was a strong sense in which speech and language therapy for many, but not all the interviewees, was described (possibly unconsciously) as a 'soft option' compared to the apparently more rigorous (male-dominated) disciplines of medicine, law and accountancy. These latter careers were seen, for instance, as requiring the ability to think logically and rationally, qualities which some interviewees felt they lacked. Speech and language therapy was on occasion chosen as a non-scientific option in line with self-perceptions of difficulty with science, even though compared with girls as a whole, these women were more biased towards science at 'A' level.

Also, in line with dominant discourses around gender, many interviewees opted for the career because of the humanistic, applied aspects of the work, i.e. the caring elements. This decision developed in many cases out of the 'caring careers' on which many research participants had already embarked informally as girls and young women.

A major influence running through the interviewees' account of their paths into speech and language therapy was the ideology of the family which traditionally assumes the role of the woman as wife and mother. This had several effects, including influencing attitudes to careers and salary. Speech and language therapy was widely regarded as a career entered not to earn a good salary but to provide a salary which would supplement the main income (most likely that of the male breadwinner). Along with this was the idea that speech and language therapy was not an ambitious option, but something which women could 'fall back on' once they got married and had children.

The interview data indicated that though the research participants entered speech and language therapy, by and large, because of the human element of the work, the course itself, particularly in recent years, focused on the mechanical aspects of human communication. People who graduated in the eighties and nineties highlighted the increasingly scientific emphasis of the speech and language therapy curriculum including the introduction of statistics, linguistics and acoustic phonetics. The practical element of the course was in many participants' experiences downplayed. There were ambivalences around notions of 'science' with regard both to therapists' low self-esteem in doing scientific work and in relation to the usefulness of science as applied to patient care.

The participants' recollections of expectations as young girls were to some extent borne out by their experiences having qualified (see Chapter 8). The accounts discussed in this chapter indicated that female interviewees living in a family situation took the main responsibility, by and large, for unpaid caring functions in the family, in particular child care and housework. If child care for younger children was not undertaken by the therapists themselves, a female relative was in some cases enlisted, though in one instance a father carried out child care on a regular basis. It appeared that even in the NHS which is female-dominated, workplace child care facilities were extremely limited and not an option taken up by any of the interviewees. Thus even though there have been moves to improve state child care provision, discussions around encouraging men to be more involved in child care through the provision of paternity leave (Dyer 2000) and challenges to the ideology of the mother as primary carer, the reality was that mothers did most of the caring work.

The importance of gender as a factor in speech and language therapists' careers was also underlined in these data in that many participants adopted career patterns women in general take up to accommodate both work and family life. These include 'chequered' career paths with women leaving and re-entering the labour market to

accommodate periods out of work for maternity leave and child-rearing, working part-time hours, taking on private clients, taking a job nearer home and taking paperwork home. It should be said, however, that despite material constraints which impinged on therapists' careers (and these constraints were not necessarily seen in a negative light by all therapists), many interviewees had achieved successful careers in clinical, academic and management terms.

Chapter 9 indicated, according to the interview data, that though speech and language therapy models itself along scientific lines, its status as a health care profession continues to be problematic. Though the image of the profession has improved, there was still concern over widespread ignorance about the nature and scope of the work and the level of training required. This was reflected in inadequate pay and poor conditions and the hierarchical subordination of speech and language therapy in the NHS. The data highlighted a connection between gender and the low status of the profession and the view was expressed that the entry of men into the profession would change this situation.

Despite the low status of speech and language therapy, the interview data indicated that in terms of professional practice, the occupation took on a highly scientific approach to the work akin to the high status, male-dominated professions including medicine. Though there were considerable ambivalences around the application of science to the treatment of human communication disorders, professional practice was shown to be underpinned largely by the medical paradigm of causation and symptomology, thus (archetypally) diagnosis would lead logically to cure. This approach emanated from the professional education which put forward the idea that the patient could be 'cured' once the correct test had identified and defined the problem and the appropriate treatment had been instigated. A large part of practice for a number of therapists centred around diagnostic work and was, for one therapist, her primary role. A major focus of practice, again an area of tension for many therapists, was the focus of therapy on the disorder, rather than person or the cultural context. This reflects the reductionist, body-as-machine approach of biomedicine.

Finally, the data highlighted the idea of the therapist as 'detached expert'. While many therapists, particularly through work experience, stressed the importance of the relationship between therapist and patient, this clearly went against the scientific paradigm of retaining emotional distance. This appeared to emanate from the professional training which placed emphasis on the mechanistic aspects of therapy rather than on interpersonal, humanistic issues.

The analysis of speech and language therapy presented in this thesis would indicate that the image of the profession is largely in opposition to the reality, in terms of its education, practice and research. The thesis challenges the idea that the course is a 'soft option' (a characterisation present in a number of the interviewee's accounts), that its research is based on unscientific methods, and that its practice is based on foundations other than the scientific, biomedical paradigm. The evidence presented indicates that the nature of research, education and practice has been modelled along biomedical lines, with speech and language therapy education becoming increasingly so.

These two opposing views of speech and language therapy are visible in the tensions and contradictions present in the research participants' stories. I have argued that gender and science are significant in giving rise to these tensions and contradictions. On the one hand the 'non-scientific', caring elements of practice were highlighted as valuable (and indeed the main rationale for entering speech and language therapy), but these tended to be subordinated to science from the start of professional education. The 'non-scientific' elements were discussed in ambivalent terms, appearing to be aspects from which therapists distanced themselves. The scientific aspect of speech and language therapy was similarly seen as contradictory. Its value was both appreciated and questioned. This contradiction was further reflected in therapists' own ambivalent feelings as regards their ability to be scientists.

The gendered character of science - non-science dichotomy has been highlighted in this thesis, such that 'non-science' is equated with women and 'science' with men.

This heightens the dilemma for a female occupation which must emphasise 'science' to increase its status and downplay its female-gendered elements.

11.4 Concluding remarks to discussion of empirical and theoretical findings

I have shown in this thesis that speech and language therapists' careers cannot be understood without reference to the sexual division of labour in general. Gender ideology not only influenced the research participants' choice of career but also their work experiences, even though this ideology was on occasion resisted and subverted. For many interviewees speech and language therapy was chosen as a career option consonant with ideological constructions of womanhood and motherhood, a major feature of the profession being that it was a 'caring' profession and was thus suited to the feminine character. These speech and language therapists perceive that other people view the profession as low-skilled and requiring little training - a caring job requiring little 'science'. This perception accords with stereotypical notions of women's work as needing few learnt skills. In stark contrast, the analysis presented in this thesis has pointed to the way in which speech and language therapy has modelled itself along biomedical lines, with lengthy education in the 'science' of human communication and speech and language therapy practice which is, in the main, disorder-focused. This contradictory position is reflected in the accounts of the therapists interviewed for this research.

Though I have pointed to science and care as a gender issue, it is clear that the pull between the scientific and the humanistic aspects of health care is not confined to speech and language therapy alone, though there may be a risk that emphasising care as opposed to science may 'devalue' male-dominated areas. In medical accounts, science and care tend to be depicted at opposing ends of the spectrum with science predominating over care (as in speech and language therapy). Medicine is described as science, for instance, in Craft's account of medical education (Craft 1993) when she says:

> Doctors, as scientists, are trained to approach all problems by division: the aim is to find the smallest single offending member which can be held responsible for the broken part (p.197).

Yet Craft expresses in her account the difficulty she had detaching emotionally from her patients. She then goes on to question the need to do so, as long as the ability to help others in distress is not impaired. A further example of the importance of care to medicine is described in Patrick Wakeling's account of having a mental breakdown while working as a senior registrar in psychiatry (Wakeling 1993). He describes how through his experience he became aware of the importance of the doctor-patient relationship:

> What matters most to the patient is what mattered most to me: namely, the personal 'accessibility' of the psychiatrist - those subtle qualities of personality rendering him non-judgemental and a fully paid-up member of the human race (p.58).

The findings of this thesis point to a number of implications for speech and language therapy research, education and practice.

As regards research, claims that speech and language therapy research is 'unscientific' need to be countered. As Chapter 4 indicated, research in the field is carried out along traditional scientific lines. Once this tendency is acknowledged, the profession should be in a position to adopt far broader research methodologies rather than employ, almost exclusively, quantitative methods (particularly experimental designs). At the same time the profession perhaps needs to be mindful of the polarisation between quantitative and qualitative methodologies; it should be wary of becoming embroiled in this debate.

Future research should consider the findings of this thesis in relation to the profession's tendency to take a scientific, biomedical view of human communication. Cultural factors including ethnic, class and gender issues need greater focus. Research should also focus more on how communication disorders are manifested in real-life situations rather than in closely-controlled experimental conditions. A further area which may be usefully explored are dimensions of speech and language therapy practice as experienced from the therapist's perspective. One fruitful area of

research might be to look at the complexity of 'emotion work' speech and language therapy involves. An excellent example of such research has been carried out in nursing (Meerabeau and Page 1998). This provides a powerful account of the emotion work involved in cardiopulmonary resuscitation.

This thesis suggests a number of recommendations for professional education. At present social science is not a core subject on the curriculum. Introducing a social science module would enable educators to introduce the science debate to students, including the critique of science from gender and disability perspectives. This module would usefully include teaching on the sociology of health illness which would assist students to situate health, and more specifically human communication, in their social contexts. Following on from the above recommendations on research, these findings suggest that students should be instructed not only in experimental design and statistics but in other approaches to research.

As regards professional practice, the findings point to the need for speech and language therapists to become aware of gender and science and their influence on their professional lives and practice. Indeed, there is awareness at international and European levels of the need to focus on women and their relationship to science (Glover and Bebbington 2000). Raising therapists' awareness of these issues may lead to greater confidence in their scientific ability and may enable them to challenge stereotypical notions of the work and also of science.

A further implication for professional practice is that of examining its scientific nature. A useful point of departure for future practice may be to consider more critically the construction of clinical categories used in the field of human communication disorders. This task has already been attempted for psychopathology (Parker, Georgaca, Harper, McLaughlin and Stowell-Smith 1995).

This thesis has considered the theme of gender and science in the professionalisation of an invisible occupation. This may seem a relatively insignificant task. Yet the

importance of a revaluation of science by women has been forcefully underlined by Adrienne Rich (1979) who wrote that:

> '.....it is in the realm of the apparently unimpeachable sciences that the greatest modifications and revaluations will undoubtedly occur. It may well be in this domain that has proved least hospitable or attractive to women - theoretical science - that the impact of feminism and women-centered culture will have the most revolutionary impact' (p.142).

Speech and language therapists are eminently suited to join in this challenge.

GLOSSARY

AAC acronym for 'alternative and augmentative communication' which refers to non-speech based modes of communication such as key-board activated voice output systems.

Aphasia difficulty with language resulting from brain damage.

Autistic continuum range of disorders included within the diagnosis of autism from those involving social interaction problems, cognition and language delay to those where interaction difficulty is primary, e.g. Asperger's syndrome.

Cerebellum part of the brain important for coordinating voluntary movement.

Cerebro-vascular accident interruption of blood flow to the brain which may cause damage to the surrounding cerebral tissue.

Cleft palate congenital problem caused by the failure of the palate to close during embryological development.

Cochlear implant surgical procedure to the inner ear aimed at improving the hearing of (primarily) deafened adults.

Cognitive neuropsychology field of study which constructs theoretical models of psychological functions including language, perception and memory by studying the performance of neurological patients.

Communicative competence speaker's knowledge about the kind of language which is appropriate for specific contexts.

Cranial nerves these pass motor and sensory impulses between the brain and the structures of the head, including the face, tongue, lips, larynx and soft palate.

Developmental speech and language delay childhood problem where although speech and/or language develop in the 'normal' sequence, these skills are acquired at a slower rate.

Developmental speech and language disorder childhood disorder in which speech and/or language do not develop according to 'age appropriate' norms. The term 'disorder' is commonly used to describe a problem characterised by a pattern of development which does not follow the 'normal' sequence.

Discourse in linguistics, speech or writing longer than one sentence, e.g. a paragraph or conversation. In sociology, language relating to the interests of a certain group. 'Dominant' discourses are those controlled by powerful groups, for example, medical influence over disease definitions.

Dysarthria difficulty with speech output due to neurological or structural impairment.

Dysfluency see **fluency disorders**

Dyslexia reading disorder.

Dysphagia difficulty swallowing from birth or as a result of disease, e.g. stroke.

Dysphonia disorder of voice production.

Dysphasia see **aphasia**.

Dyspraxia disorder in the execution of movement. Movements may be possible in isolation but cannot be used purposively, as in childhood speech dyspraxia or dressing dyspraxia after stroke.

Electropalatography acoustic recording of speech articulation achieved by placing an artificial palate with electrodes inside the mouth. Tongue to palate contact in speech is reproduced graphically on a screen.

ENT Acronym for 'ear, nose and throat'. The medical speciality ENT specialises in diseases of these parts of the anatomy.

Fluency disorders stammering and related problems.

Fricative consonant produced by partial occlusion of the airstream, such as 's', 'f', 'sh', 'z', 'v'.

Hypernasality speech quality perceived as excessively nasal.

LARSP Language Assessment, Remediation and Screening Procedure, a system used to analyse the grammatical structures in a given language sample. Based on the work of Crystal, Garman and Fletcher, 1976.

Laryngectomy removal of the larynx most often resulting from laryngeal cancer.

Laryngography analysis of vocal output using a Laryngograph. The subject speaks into a microphone attached to an oscilloscope. The voice is translated into waveforms which are displayed on a screen.

Lesion damage to a system or anatomical part of the body.

Linguistics the study of language.

Nasal consonant consonant produced with the airstream passing through the nasal cavity, e.g. 'n', 'm', 'ng'.

Nasal emission airflow through the nose during the production of oral consonants.

Neuroanatomy the anatomy of the neurological system.

Neurology study of the anatomy, physiology and diseases of the nervous system.

Neuropsychology study which attempts to 'localise' psychological functions such as memory, language and intellect within particular areas of the brain.

NG tube nasogastric tube. A flexible tube passing from the nose to the stomach through which liquid diet is fed.

PEG - percutaneous endoscopic gastrostomy. A plastic feeding tube inserted into the stomach wall under local anaesthetic.

Phoneme one of a group of speech sounds in any particular language which serves to distinguish one word from another.

Phonetics the study of speech sounds.

Phonology the study of sound systems and how they behave in a language.

Phonological delay/disorder difficulty children may have in developing their phonological system.

Pragmatics the use of language in context.

Progressive neurological disorders illnesses associated with damage to the nervous system leading to a decline in health, including Parkinson's Disease, motor neurone disease and dementia.

Psycholinguistics the psychology of language, including the acquisition of language by children.

Resonance the amplification of the voice through modifications to the position of the speech tract, often likened to the strings of a violin whose sound is amplified by the resonating body of the instrument.

Semantic/pragmatic disorder a group of child language problems characterized by difficulties with the semantic and pragmatic aspects of language.

Semantics the study of meaning.

Syntax sentence structure.

Transformational grammar Chomskyan theory of grammar in which Chomsky proposed that humans have an innate 'language acquisition device'. Through this device grammatical rules are derived. Core sentences or 'deep structures' are operated on by transformational rules into 'surface structures', such as the passive transformation: *Derek drives a Porsche⇒A Porsche is driven by Derek.*

Velophargyngeal anomaly poor closure of the sphincter between the soft palate and the back of the pharynx resulting in nasal speech and/or difficulty swallowing. May be structural or neurological in origin.

Visual agnosia a disorder resulting from neurological damage characterised by normal vision, but an inability to recognise seen objects.

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